

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00619

630

## CERTIFICATE OF DEATH

Reg. Dist. No. 180-

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND CITY OR TOWN <u>Harford</u> (If outside corporate limits, write RURAL and give nearest town) HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Mem. Hosp.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY OR TOWN <u>Joppa</u> (If outside corporate limits, write RURAL and give nearest town) STREET ADDRESS <u>Md.</u> (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>MAE</u> <u>Mary</u> <u>B.</u> <u>ACKERMAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 11</u> <u>19</u> <u>56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>May, 15, 1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self employed</u>		11. BIRTHPLACE (State or foreign country) <u>Shrewsbury Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wilkes</u>				14. MOTHER'S MAIDEN NAME <u>Sweeney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Herbert Budnick Joppa, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Pneumonitis - bilateral, hypostatic</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular disease</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Gangrene of left foot due to peripheral arteriosclerosis</u>						<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>Dec. 17th, 55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Gangrene of left foot</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 4th, 1955</u> to <u>Jan 11th, 1956</u> , that I last saw the deceased alive on <u>Jan 11th, 1956</u> , and that death occurred at <u>11:40 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Howard K. McComas</u>		M.D. <u>R.N. Union Ave. Harford, Md.</u>		DATE SIGNED <u>1/11/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 14, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran</u>		LOCATION (City, town, or county) (State) <u>Joppa, Harford, Md.</u>	
24. REC'D BY REGISTRAR <u>Jan. 14 - 1956</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas &amp; Son, Abingdon, Md.</u>			

# CERTIFICATE OF DEATH

1. Name of deceased: \_\_\_\_\_  
2. Sex: \_\_\_\_\_  
3. Age: \_\_\_\_\_  
4. Date of birth: \_\_\_\_\_  
5. Place of birth: \_\_\_\_\_  
6. Date of death: \_\_\_\_\_  
7. Place of death: \_\_\_\_\_  
8. Cause of death: \_\_\_\_\_  
9. Manner of death: \_\_\_\_\_  
10. Signature of physician: \_\_\_\_\_  
11. Signature of registrar: \_\_\_\_\_  
12. Date of registration: \_\_\_\_\_

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
This certificate is to be filled out by the physician attending the deceased, or by the registrar if the deceased was not attended by a physician.  
The cause of death should be stated in full, and the manner of death should be stated as natural, accidental, or suicidal.  
The signature of the physician or registrar must be written in ink, and the date of registration must be written in ink.

BUREAU V. 3

JAN 17 1956

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00620

631

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Hartford</u>		STATE <u>Md.</u> COUNTY <u>Hartford</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		TOWN <u>Aberdeen</u>		TOWN <u>Aberdeen</u>	
TOWN <u>Harrods-Croce</u>				STREET ADDRESS (If rural give location)		STREET ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Memorial Hospital</u>				<u>477 W. Bel Air Ave</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>John Victor Adams</u>				<u>1-25-56</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>10. IF UNDER 1 YEAR</b>	<b>11. IF UNDER 24 HRS.</b>	
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>July 13-1888</u>	<u>67</u> yrs.	Months	Days	Hours
<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Grocer</u>		<u>Self-employed</u>		<u>Maryland</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>William Adams</u>				<u>Emma Bristow</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT'S ADDRESS</b>			
		<u>218-32-1691</u>		<u>Rev. B. Adams/35 E Bel Air Ave</u>			
<b>18. MEDICAL CERTIFICATION</b>							
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>420.1 IMMEDIATE CAUSE (A)</b> <u>Crownary Thrombosis</u>							
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Crownary Atherosclerosis</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>April 1955</u>, to <u>Jan 1956</u>, that I last saw the deceased alive on <u>Jan 25</u>, 19<u>56</u>, and that death occurred at <u>6:20 P</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Reph Horky</u> M.D.				<b>DATE SIGNED</b> <u>Jan 25</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>Jan 28 1956</u>		<u>Bakers Cemetery</u>		<u>Aberdeen Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS			
<u>Jan 28-1956</u>		<u>G. L. Lewis M.D.</u>		<u>John F. Harring Aberdeen Md.</u>			

# CERTIFICATE OF DEATH

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Place of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Manner of death: \_\_\_\_\_

10. Signature of physician: \_\_\_\_\_

11. Signature of registrar: \_\_\_\_\_

12. Signature of informant: \_\_\_\_\_

13. Signature of witness: \_\_\_\_\_

14. Signature of witness: \_\_\_\_\_

15. Signature of witness: \_\_\_\_\_

16. Signature of witness: \_\_\_\_\_

17. Signature of witness: \_\_\_\_\_

18. Signature of witness: \_\_\_\_\_

19. Signature of witness: \_\_\_\_\_

20. Signature of witness: \_\_\_\_\_

21. Signature of witness: \_\_\_\_\_

22. Signature of witness: \_\_\_\_\_

23. Signature of witness: \_\_\_\_\_

24. Signature of witness: \_\_\_\_\_

25. Signature of witness: \_\_\_\_\_

RECEIVED  
JAN 30 1930  
BUREAU V. S.

1. Name of deceased: \_\_\_\_\_  
2. Sex: \_\_\_\_\_  
3. Age: \_\_\_\_\_  
4. Date of birth: \_\_\_\_\_  
5. Place of birth: \_\_\_\_\_  
6. Date of death: \_\_\_\_\_  
7. Place of death: \_\_\_\_\_  
8. Cause of death: \_\_\_\_\_  
9. Manner of death: \_\_\_\_\_  
10. Signature of physician: \_\_\_\_\_  
11. Signature of registrar: \_\_\_\_\_  
12. Signature of informant: \_\_\_\_\_  
13. Signature of witness: \_\_\_\_\_  
14. Signature of witness: \_\_\_\_\_  
15. Signature of witness: \_\_\_\_\_  
16. Signature of witness: \_\_\_\_\_  
17. Signature of witness: \_\_\_\_\_  
18. Signature of witness: \_\_\_\_\_  
19. Signature of witness: \_\_\_\_\_  
20. Signature of witness: \_\_\_\_\_  
21. Signature of witness: \_\_\_\_\_  
22. Signature of witness: \_\_\_\_\_  
23. Signature of witness: \_\_\_\_\_  
24. Signature of witness: \_\_\_\_\_  
25. Signature of witness: \_\_\_\_\_

1

662

## CERTIFICATE OF DEATH

See: Stillbirth Cert. Twin I

Reg. Dist. No. 181

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>X</u> <u>Aberdeen</u>		LENGTH OF STAY (in this place) <u>1 hr 53 min</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Aberdeen Edgewood</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 US Army Hospital</u> <u>Aberdeen Proving Ground</u>				STREET ADDRESS <u>#2 Zetter St.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>MARIE</u> (First) <u>-</u> (Middle) <u>ADAMS Twin II</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>January</u> (Day) <u>17</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>January 17 1956</u>	9. AGE last birthday yrs. <u>1</u> Months <u>53</u> Days <u>1</u> Hours <u>53</u> Min.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>53</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Russell Clark Adams</u>				14. MOTHER'S MAIDEN NAME <u>Sylvia June Furnace</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Father</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
774X IMMEDIATE CAUSE (A) <u>Prematurity</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Polyhydramnios</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> M. <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>17 Jan</u> , 19 <u>56</u> , to <u>17 Jan</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>17 Jan</u> , 19 <u>56</u> , and that death occurred at <u>7:00a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>John G. Herring</u>		DATE THEREOF <u>Jan 20 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Post Cemetery</u>		LOCATION (City, town, or county) (State) <u>Harford County, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Jan 19-56</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Herring</u>		ADDRESS <u>Aberdeen road</u>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

2150234320



# CERTIFICATE OF DEATH

Page One of Two

1. USUAL RESIDENCE - HOME OR BUSINESS

2. PLACE OF DEATH

3. MANNER OF DEATH

4. NAME OF PHYSICIAN

5. DATE OF DEATH

6. PLACE OF BURIAL

7. NAME OF FUNERAL HOME

8. MEDICAL CERTIFICATION

9. I hereby certify that the deceased was at the time of death in the following condition:

BUREAU V. S.

JAN 20 1956

RECEIVED

DEPARTMENT OF HEALTH

OFFICE OF THE REGISTRAR  
DEPARTMENT OF HEALTH  
BALTIMORE, MARYLAND  
JAN 20 1956

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00621

632

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		STATE <u>Maryland</u> COUNTY <u>HARFORD</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>HAURE de GRACE</u>				TOWN <u>Aberdeen</u>		TOWN <u>Aberdeen</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>43 Aberdeen Ave</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>Harold</u>		(Middle) <u>Raymond</u>		(Last) <u>Alpaugh</u>		<u>JANUARY 18 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Feb 11th 1893</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Security Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt. A.P.P. Bd</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wesley Abgar Alpaugh</u>				14. MOTHER'S MAIDEN NAME <u>Eurina Waters</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>149-07-9244</u>		17. INFORMANT & ADDRESS <u>Mrs Harold Alpaugh 43 Aberdeen Ave</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
480.1 IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>14 hours</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>Nov 54</u> , to <u>Jan 18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>18 JANUARY 1956</u> , and that death occurred at <u>10:55 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. H. Hatten</u>				ADDRESS (Street, city, town, state) <u>Baltimore, Maryland</u>			
DATE <u>Jan 20-1956</u>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>Jan 21-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematory</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>G. L. Lewis M. D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Tarrying</u>		ADDRESS <u>Aberdeen Md.</u>	

10001

MASSACHUSETTS DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

CAUSE OF DEATH

BUREAU V. S.

JAN 23 1956

RECEIVED

20001

1. Name of deceased  
2. Date of birth  
3. Place of birth  
4. Date of death  
5. Place of death  
6. Age at death  
7. Sex  
8. Race  
9. Cause of death  
10. Signature of physician  
11. Signature of registrar  
12. Date of registration



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-45 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00622

633

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>31 Aberdeen</i>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>31 Aberdeen</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>437 W. Bel Air Ave.</i>				STREET ADDRESS (If rural give location) <i>437 W. Bel Air Ave.</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Minnie</i> (First) <i>Baer</i> (Last)				<b>4. DATE OF DEATH</b> (Month) <i>Jan</i> (Day) <i>31st</i> (Year) <i>1956</i>			
<b>5. SEX</b> <i>Female</i>	<b>6. COLOR OR RACE</b> <i>White</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>Married</i>	<b>8. DATE OF BIRTH</b> <i>Aug 3-1906</i>	<b>9. AGE last birthday</b> <i>49</i> yrs.	<b>IF UNDER 1 YEAR</b> (Month) (Day) (Year)		<b>IF UNDER 24 HRS.</b> (Hours) (Min.)
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>House wife</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Home</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Germany</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>	
<b>13. FATHER'S NAME</b> <i>unknown</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Minnie Gerlach</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Shelton Baer - Aberdeen Md.</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>330X IMMEDIATE CAUSE (A)</b> <i>(Subarachnoid) Haemorrhage, Spontaneous</i>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>Terminal</i>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <i>Pulmonary Edema (a)</i>				<b>Terminal</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <i>M.</i>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <i>1956</i> <b>to</b> <i>1-31-</i> <b>1956</b> <b>that I last saw the deceased alive on</b> <i>1-31-</i> <b>1956</b> <b>and that death occurred at</b> <i>11:05 P.M.</i> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>John G. Harving</i>				<b>DATE SIGNED</b> <i>2-2-56</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>		<b>DATE THEREOF</b> <i>2/4/56</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Portwood Cemetery</i>		<b>LOCATION (City, town, or county) (State)</b> <i>Baltimore, Maryland</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Hellie G. Perry</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>John G. Harving</i>			
<b>DATE</b> <i>Feb 3-1956</i>				<b>ADDRESS</b> <i>Aberdeen Md.</i>			

100-20

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

# CERTIFICATE OF DEATH

203

DATE OF DEATH

PLACE HERE THE NAME OF THE DECEASED

PLACE HERE THE NAME OF THE DECEASED

INSTRUCTIONS

BUREAU V. 2

FEB 6 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

00623

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Ind.</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harre de Grace</u>		<u>2 days</u>		TOWN <u>Perryville</u>		<u>07.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				RURAL ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>James</u> (Middle) <u>H</u> (Last) <u>Benedict</u>				(Month) <u>Jan</u> (Day) <u>4</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 23, 1904</u>	9. AGE last birthday <u>51</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Craft Assembler</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Penna.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Ruben Benedict</u>				14. MOTHER'S MAIDEN NAME <u>Jenny Black</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>185-03-1739</u>		17. INFORMANT & ADDRESS <u>Mrs. Mabel Benedict, Perryville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Posterior Coronary Thrombosis acute</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Disease</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 2nd</u> , 1956, to <u>Jan 4th</u> , 1956, that I last saw the deceased alive on <u>Jan 4th</u> , 1956, and that death occurred at <u>10:25 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city, town, state) <u>221 North Union Ave. Harre de Grace, Ind.</u>		DATE SIGNED <u>1/4/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1-7-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Chestnut Level</u>		LOCATION (City, town, or county) (State) <u>Perryville, Pa.</u>	
24. REC'D BY REGISTRAR <u>Jan 8-1956</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Patterson</u>		ADDRESS <u>Perryville, Md.</u>	

Good

Feb. 23, 1904 21

182-03-1729 Mrs. Mary Benedict, Grand

Grand - 182-03-1729 (182-03-1729) Grand - 182-03-1729  
Grand - 182-03-1729 (182-03-1729) Grand - 182-03-1729

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00624

## CERTIFICATE OF DEATH

Item 8, Film 93 2-28-56 et

Reg. Dist. No. 183-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		STATE <u>Md.</u> COUNTY <u>Harford</u>		CITY (if outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		CITY (if outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>	
CITY OR TOWN <u>Harre-de-Grace</u>		LENGTH OF STAY (in this place)		STREET ADDRESS <u>Revolution St.</u>		(if rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>							
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Mamie</u> (First) <u>BRINKMAN</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>JAN.</u> (Day) <u>7</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>MARRIED</u>	<b>8. DATE OF BIRTH</b> <u>1887</u>	<b>9. AGE last birthday</b> <u>68</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u></u> Days <u></u>	<b>IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>CHARLES RYAN</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>MARIE CHRISTESON</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u></u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u></u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Charles Brinkman (husband)</u>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>443X IMMEDIATE CAUSE</b> (A) <u>Cardiac decompensation</u>				<u>1 week</u>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> (B) <u>Hypertensive cardio-vascular disease</u>				<u>1 year</u>			
<b>STATING UNDERLYING CAUSE LAST.</b> (C) <u></u>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County)</b> <b>(State)</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Minute) <u></u> M. <u></u> al work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>1/31</u> , 19 <u>56</u> , to <u>1/7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>JAN 7</u> , 19 <u>56</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Wm. H. Wachmann M.D.</u>				<b>DATE SIGNED</b> <u>1/9/56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>				<b>DATE THEREOF</b> <u>JAN 10 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>ANGEL HILL CEM.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Jan 9-1956</u>				<b>REGISTRAR'S SIGNATURE</b> <u>G. D. Lewis M.D.</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>R. Madison Mitchell</u>	
<b>DATE</b>				<b>ADDRESS</b> <u>Harre-de-Grace, Md.</u>			



22 200 200

200

200 200 200

200 200 200

200 200

200 200

200 200 200 200 200 200 200 200

## CERTIFICATE OF DEATH

663

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		MARYLAND		STATE <del>New York</del> New York		COUNTY New York	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Aberdeen		1 day		TOWN <del>New York</del> New York			
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Army Hospital Aberdeen Proving Ground, Md				STREET ADDRESS (see birth <del>2115 Firethorn Rd</del> ) 700 West 178 St. ✓			
3. NAME OF DECEASED (First) (Middle) (Last) (NOT NEEDED) BROTMAN				4. DATE OF DEATH (Month) (Day) (Year) Jan 11 19 56			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Jan 11 1956	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min. 2 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gerald Brotman				14. MOTHER'S MAIDEN NAME Elsbeth Jonas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Father 2115 Firethorn Rd, Baltimore 20 Md			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Fetal prematurity							
ANTECEDENT CAUSE(S) DUE TO Maternal congenital anomalies of uterus							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11 Jan 19 56, to 11 Jan 19 56, that I last saw the deceased alive on 11 Jan 19 56, and that death occurred at 1100a M, from the causes and on the date stated above.							
SIGNATURE Robert W. James Jr.				ADDRESS (Street, city, town, state) M.D. US Army Hospital APG, Md		DATE SIGNED 12 Jan 56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan 16th 1956		NAME OF CEMETERY OR CREMATORY Post Cemetery		LOCATION (City, town, or county) (State) Aberdeen, Maryland	
24. REC'D BY REGISTRAR DATE Jan 16-1956		REGISTRAR'S SIGNATURE Thelma R Perry		25. FUNERAL DIRECTOR'S SIGNATURE John E. Farney ADDRESS Aberdeen Md.			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 30M



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00626

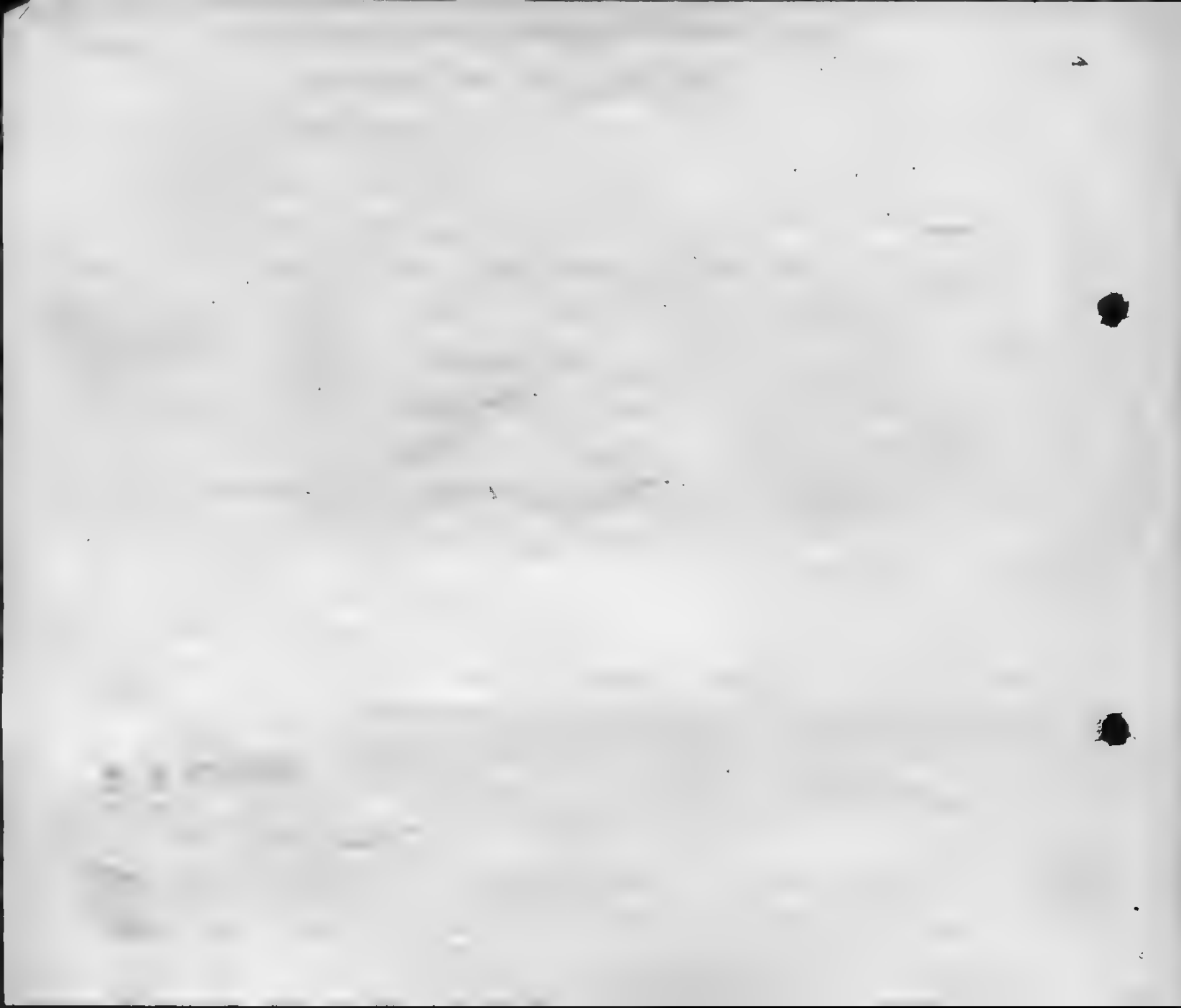
Items 20&amp;21 Film G191 1-19-56

664

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Tid</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Bel Air</u>				TOWN <u>Rocks</u>		Rural	
HOME OR INSTITUTION OR STREET ADDRESS <u>Route #1 Highway</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Owen Lee Brown</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>January 7 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 9-1932</u>	9. AGE last birthday <u>23</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>20</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>H-T Campbell &amp; Co</u>		11. BIRTHPLACE (State or foreign country) <u>North York Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Moffitt Brown</u>				14. MOTHER'S MAIDEN NAME <u>Maude Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>187-24-6666</u>		17. INFORMANT & ADDRESS <u>Bernice Jean Brown Rocks Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Fracture Skull</u>				INTERVAL BETWEEN ONSET AND DEATH <u></u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>US Route 1</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Fallston Harford Md</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Jan. 7, 1956 PM. 11:20</u>		21e. INJURY OCCURRED <input type="checkbox"/> White <input checked="" type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Auto accident, auto-object type</u>			
<b>22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.</b>							
SIGNATURE <u>Gerald E Palmer</u> M.D. <u>Deputy Medical Examiner</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>1/8/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 11-56</u>		NAME OF CEMETERY OR CREMATORY <u>Bel Air Mem. Park</u>		LOCATION (City, town, or county) (State) <u>Bel Air Md</u>	
24. REC'D BY REGISTRAR <u>1-11-56</u>		REGISTRAR'S SIGNATURE <u>Maxine Foxwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Rusty</u>		ADDRESS <u>Rock</u>	





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

665

## CERTIFICATE OF DEATH

00627

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>N.Y.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Rural HAVRE DE GRACE 2 M.O.S.</u>				TOWN <u>SHORTSVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HAVRE DE GRACE HEIGHTS</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>PARKER</u> (Middle) <u>LESTER</u> (Last) <u>BROWN</u>				(Month) <u>JAN.</u> (Day) <u>11</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>MAY 23 1884</u>	<u>71</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>RETIRED</u>		<u>HARDWARE DEALER MD.</u>		<u>MD.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. HENRY BROWN</u>				14. MOTHER'S MAIDEN NAME <u>(RICHARD) ALICE PARKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mrs. RICHARD E. PEASIN.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arterio Sclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-18</u> , 19 <u>55</u> , to <u>1-7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-6</u> , 19 <u>56</u> , and that death occurred at <u>12:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>Harford Grace Md.</u>			
				DATE SIGNED <u>1-12-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>JAN 13, '56</u>		<u>ANGEL HILL Cm.</u>		<u>HAVRE DE GRACE MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Jan. 12 - 1956</u>		<u>G. L. Lewis M.D.</u>		<u>P. Madrin Mitchell</u>		<u>Harford Grace Md.</u>	

NY

100-111111

100-111111

100-111111

100-111111

100-111111

100-111111

100-111111

100-111111

100-111111

100-111111

100-111111

100-111111

100-111111

100-111111

1

836

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Hartford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harvode Grace</u>				TOWN <u>BEL AIR</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>Rd #1, Separate Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>James M. Cardwell</u>				A. DATE OF DEATH (Month) (Day) (Year) <u>January 9 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Child</u>	8. DATE OF BIRTH <u>June 21 1953</u>	9. AGE last birthday <u>6 years</u>	IF UNDER 1 YEAR / IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harrison L. Cardwell</u>				14. MOTHER'S MAIDEN NAME <u>Sybil E. (Sparks)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>HARRISON L. Cardwell 1624 IR MD Route 3</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Septicemia</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>ac. infectious diarrhea</u>						Sole	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Jan 8 1956</u> to <u>Jan 9 1956</u> , that I last saw the deceased alive on <u>Jan 9 1956</u> , and that death occurred at <u>5:30 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>William P. Hudson M.D.</u>				DATE SIGNED <u>1/9/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 10/56</u>		NAME OF CEMETERY OR CREMATORY <u>BEL AIR Memorial Garden</u>		LOCATION (City, town, or county) (State) <u>BEL AIR HARTFORD MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>W. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Forest Hill Md</u>			
DATE <u>Jan. 12 - 1956</u>		ADDRESS (Street, city, town, state) <u>Forest Hill Home, Forest Hill, Md</u>					

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

3. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

066

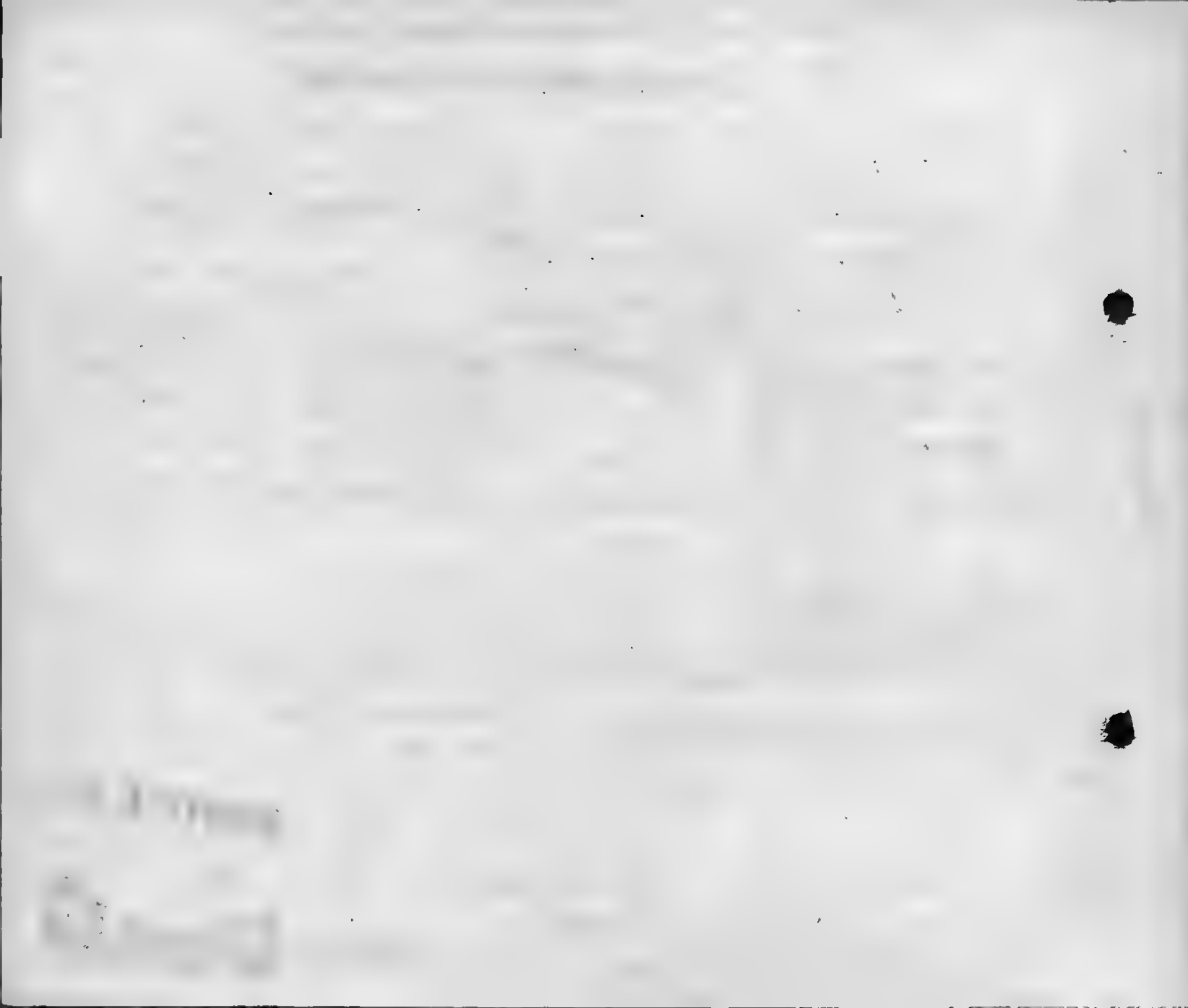
## CERTIFICATE OF DEATH

00629

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Hartford</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>Hartford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Kalma</i>		<i>10 mo</i>		TOWN <i>Hartford Forest Hill</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Hartford Convent. Home</i>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Edna Virgittia Cart</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>JAN. 27 1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>Aug 5-1878</i>	9. AGE last birthday <i>77</i> yrs.	IF UNDER 1 YEAR Months <i>5</i> Days <i>22</i>		IF UNDER 24 HRS. Hours <i>24</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Henry Christy</i>				14. MOTHER'S MAIDEN NAME <i>Alice Ann Greaser</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Adrian B Christy wife of</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
4. IMMEDIATE CAUSE (A) <i>Acute Coronary Occlusion probable.</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 minute</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerotic (C-V-D)</i>				10 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>1904-71</i>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Fracture, Tibia, Left - Post Operative</i>				11 months			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>5/13</i> , 19 <i>47</i> , to <i>1/27</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>12/10</i> , 19 <i>55</i> , and that death occurred at <i>2 P.</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Ruth Barthel</i>				ADDRESS (Street, city, town, state) <i>Forest Hill Md.</i>		DATE SIGNED <i>1/28/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Jan 30-56</i>		NAME OF CEMETERY OR CREMATORY <i>Emory</i>		LOCATION (City, town, or county) (State) <i>Emory Hartford, Md</i>	
24. REC'D BY REGISTRAR <i>1-31-56</i>		REGISTRAR'S SIGNATURE <i>Pucilla Lowndes</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. H. Skutz</i>		ADDRESS <i>2nd</i>	





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00630

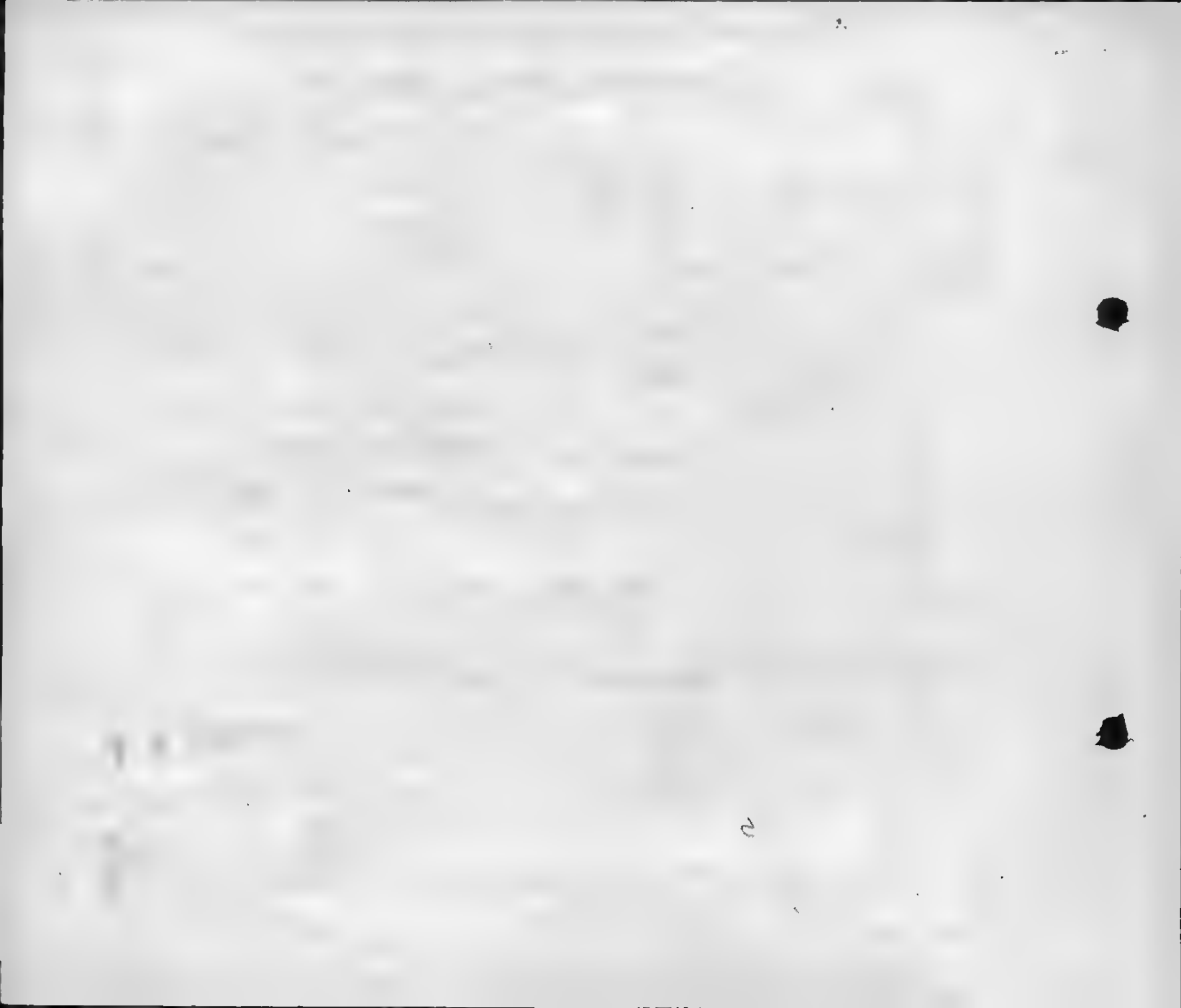
## CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		STATE <u>MARYLAND</u>		COUNTY <u>HARFORD</u>		STATE <u>MARYLAND</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)	
TOWN <u>HAVERDE GRACE</u>		<u>6 DAYS</u>		TOWN <u>ROCKS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL HOSP.</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>LAURA COCKERHAM</u>				<u>JANUARY 7 1956</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>FEMALE</u>		<u>WHITE</u>		<u>WIDOWED</u>		<u>JAN. 17 1895</u>	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday		IF UNDER 1 YEAR	
<u>HOUSEWIFE</u>		<u>—</u>		<u>70</u> yrs.		<u>0</u> Months <u>14</u> Days	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
<u>NORTH CAROLINA</u>				<u>USA</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JOHN JONES</u>				<u>MARTHA WEYER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.			
<u>NO</u>				<u>—</u>			
17. INFORMANT & ADDRESS				18. MEDICAL CERTIFICATION			
<u>Mrs. Martin Knapp Rocks Md.</u>				I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
				INTERVAL BETWEEN ONSET AND DEATH			
I IMMEDIATE CAUSE (A)				<u>CORONARY OCCLUSION</u>			
ANTECEDENT CAUSE(S) DUE TO (B)				<u>Chr Hypertensive Cardio-Vascular Disease,</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>With Atrial Fibrillation</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Chr Bronchial Asthma</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 2</u> , 19 <u>50</u> , to <u>Jan 7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Jan 7</u> , 19 <u>56</u> , and that death occurred at <u>5:30</u> A.M. from the causes and on the date stated above.		SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Willard P. Hudson</u>		<u>Forest Hill Md</u>		<u>1/7/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-10-56</u>		<u>MT Zion</u>		<u>Fountain Green Harford</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>1-11-56</u>		<u>William S. Brown</u>		<u>Trinity Church</u>		<u>Rockville Md</u>	

M. G. J. Dennis

W



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00631  
Reg. Dist.

No 802

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Harford</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Harford</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Bel Air</b>		LENGTH OF STAY (In this place) <b>12 yrs.</b>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>Bel Air</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) <b>Ellen</b> (Middle) <b>C</b> (Last) <b>Cook</b>				4. DATE OF DEATH (Month) <b>January</b> (Day) <b>20</b> (Year) <b>1956</b>			
5. SEX: <b>female</b>		6. COLOR OR RACE: <b>white</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>married</b>		8. DATE OF BIRTH: <b>Feb. 5, 1901</b>	
9. AGE Last birthday: <b>54</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during part of work life, even if retired): <b>Steno</b>		11. BIRTHPLACE (State or foreign country): <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Wilburn Gillespie</b>				14. MOTHER'S MAIDEN NAME: <b>Martha Holden</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY No.: <b>239-03-4083</b>		17. INFORMANT & ADDRESS: <b>William A. Cook, Bel Air, Maryland</b>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause (a) <b>Atherosclerotic CV disease</b> DUE TO Antecedent cause(s) (b) <b>giving rise to the above cause</b> DUE TO stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <b>Lerald C Palmer</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/20/56</b> M. D. ASSISTANT MEDICAL EXAM. <b>Howard K. McComas</b> <input checked="" type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF: <b>Jan. 23, 1956</b>		NAME OF CEMETERY OR CREMATORY: <b>William Watters</b>	
LOCATION (City, town, or county) (State): <b>Terretsville, Harford, Md.</b>		24. FUNERAL DIRECTOR: <b>Howard K. McComas &amp; Son Abingdon Md.</b>			
DATE REC'D BY LOCAL REG. <b>1-21-56</b>		REGISTERAR'S SIGNATURE: <b>Prueella Howard</b>			





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be delivered for use as a burial transit permit.

V-15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00632

639

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>	
CITY OR TOWN <u>Harre-de-Grace</u>		LENGTH OF STAY (in this place) <u>8 days</u>		CITY OR TOWN <u>Port Deposit</u>		(If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Memorial Hospital</u>				STREET ADDRESS <u>Box 576 R.D.</u>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Beulah Mae Craig</u>				<b>4. DATE OF DEATH</b> (Month) <u>1</u> (Day) <u>13</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>April 6, 1893</u>	
9. AGE last birthday <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Bunnett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Stanley Craig</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
175x IMMEDIATE CAUSE (A) <u>Cancer right ovary &amp; Ascites</u>						<u>1 yr?</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Acute hemorrhagic gastritis</u>						<u>1 month</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Chronic Pyelonephritis</u>						<u>Several years</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Old inactive rheumatic heart disease</u>						<u>30+ years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-4</u> , 19 <u>55</u> , to <u>1-13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-13</u> , 19 <u>56</u> , and that death occurred at <u>2:45</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Port Deposit, Md.</u>		DATE SIGNED <u>1-14-56</u>	
23. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Burial</u>		DATE THEREOF <u>1-17-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Box 576, Perryville, Md.</u>	

Official 1983 65

1/17/83

500

BUREAU V. S.

AN 17 1956

RECEIVED

Received 1-17-83  
Federal Bureau of Investigation  
Washington, D.C.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** This law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00633

640

## CERTIFICATE OF DEATH

Reg. Dist. No. 180-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Harre de Grace</i>		LENGTH OF STAY (In this place) <i>about 35 yrs.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Harre de Grace</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>550 Alliance St.</i>				STREET ADDRESS (If rural give location) <i>550 Alliance St.</i>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <i>A. bel. J. Cromwell</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>1 26 1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>3-6-78</i>	9. AGE last birthday <i>77</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Schoolteacher Board of Education</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>James Cromwell</i>				14. MOTHER'S MAIDEN NAME <i>Amanda O'sborn</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS <i>Mrs. Horace Cromwell - Harre de Grace, Md.</i>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <i>Cerebral Vascular Accident (Thrombosis)</i>						INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Arteriosclerotic Heart disease</i>							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <i>June 10, 1951</i> , to <i>Jan. 26, 1956</i> , that I last saw the deceased alive on <i>Jan. 26, 1956</i> , and that death occurred at <i>12:15 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>George J. Standbury</i>		DATE THEREOF <i>1-29-56</i>		NAME OF CEMETERY OR CREMATORY <i>St. James Cemetery</i>		LOCATION (City, town, or county) (State) <i>Harre de Grace, Md.</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1-29-56</i>		NAME OF CEMETERY OR CREMATORY <i>St. James Cemetery</i>		LOCATION (City, town, or county) (State) <i>Harre de Grace, Md.</i>	
24. REC'D BY REGISTRAR <i>Jan 29-1956</i>		REGISTRAR'S SIGNATURE <i>G. J. Standbury</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Charles J. Bullock</i>		ADDRESS <i>Harre de Grace, Md.</i>	





FEB

WILKINSON

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be filed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-53 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00635

641

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Hartford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harbo de Grace</u>		<u>2 DAYS</u>		TOWN <u>Bel Air</u>		<u>32</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>111 East Broadway</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Ethel</u>		(Middle) <u>Florence</u>		(Last) <u>Douglas</u>		(Month) (Day) (Year) <u>January 14 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2/7/1900</u>	9. AGE last birthday <u>55</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Loggin Woodie</u>				14. MOTHER'S MAIDEN NAME <u>Mattie Loupe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		INFORMANT & ADDRESS <u>Mr. Eula Spivey, Forest Hill Rd Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				16. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>420</u>				CORONARY OCCLUSION with myocardial infarction 48 hrs			
ANTECEDENT CAUSE(S) DUE TO				Arteriosclerotic and Hypertensive Cardio-vascular disease			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
17. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office, bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M.		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 13rd</u> , 19 <u>56</u> , to <u>Jan 14th</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 14th</u> , 19 <u>56</u> , and that death occurred at <u>4:30 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>Ethel Florence Douglas</u>		DATE THEREOF <u>Jan 17 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>		LOCATION (City, town, or county) (State) <u>Spartan Ally. Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 17 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>		LOCATION (City, town, or county) (State) <u>Spartan Ally. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>J. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u>		ADDRESS <u>Bel Air, Md</u>	

24-1-2

24-1-2



## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

642

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		STATE <u>Md.</u>		COUNTY <u>Hartford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		LENGTH OF STAY (in this place) <u>8 hrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Memorial Hospital</u>		STREET ADDRESS (If rural, give location)					
3. NAME OF DECEASED (Type or Print) <u>Walter Benjamin DUFF</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1</u> <u>1</u> <u>56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 16 - 1902</u>	9. AGE last birthday <u>53</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance, U.S. Govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles A. DUFF</u>				14. MOTHER'S MARDEN NAME <u>Fally Love</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-22-0324</u>		17. INFORMANT & ADDRESS <u>Vernon L. Tuff, Aberdeen #1. Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1X IMMEDIATE CAUSE (A) <u>Acute Pulmonary Edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cor Pulmonale</u>				<u>Yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Asthma</u>				<u>Yrs.</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/25</u> , 19 <u>55</u> , to <u>1/1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/1</u> , 19 <u>56</u> , and that death occurred at <u>9:20 PM</u> , from the causes and on the date stated above.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/4/56</u>		NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		LOCATION (City, town, or county) (State) <u>Aberdeen Maryland</u>	
24. REC'D BY REGISTRAR <u>Jan 6 - 1956</u>		REGISTRAR'S SIGNATURE <u>A. L. Lewis M. D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Barry Aberdeen Md.</u>		ADDRESS <u>Aberdeen Md.</u>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be filed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

U.S. V. S.

191

DEPT. OF JUSTICE  
RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>RURAL-WHITEFORD</u>		<u>69 yrs.</u>		OR TOWN <u>Whiteford, Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (if rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>HENRY B. ELLIS</u>				OF DEATH: <u>Jan. 26 - 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>married Jan. 9-1887</u>	<u>Jan. 9-1887</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>				<u>Harford Co. Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William T. Ellis</u>				<u>Alice R. White</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>179-09-6464</u>		<u>Myrtle Ellis, Whiteford, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Mitral Aneurysm</u>				<u>about 5 weeks</u>			
ANTECEDENT CAUSE (S) (B) <u>Myocardial infarction of 4 weeks</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>12 weeks - 1700 mm Hg</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 25, 1956</u> to <u>Jan 25, 1956</u> that I last saw the deceased alive on <u>Jan 25, 1956</u> and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>1-28-56</u>		<u>John H. Harbison, Delta, Pa.</u>		<u>Jan 27, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-28-1956</u>		<u>Mt. Vernon cemetery</u>		<u>Whiteford, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1-28-56</u>		<u>Priscilla Lowwood</u>		<u>John H. Harbison</u>		<u>Delta, Pa.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 1 1956

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00638

669

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Poplar Grove</u>		LENGTH OF STAY (in this place) <u>5 mo</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Poplar Grove, Street RD X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Arinda Claiadel Epperley</u>				<b>4. DATE OF DEATH</b> (Month) <u>Jan</u> (Day) <u>10</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Dec 21, 1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>19</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pilot, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Marion Hall</u>				14. MOTHER'S MAIDEN NAME <u>Nancy PEE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>F Everett Epperley Street</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.1 IMMEDIATE CAUSE (A) <u>CARDIO-RESPIRATORY FAILURE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>ACUTE CORONARY OCCLUSION</u>						<u>45 HOURS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>---</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1953</u> to <u>10 JAN</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10 JAN</u> , 19 <u>56</u> , and that death occurred at <u>11:30</u> M., from the causes and on the date stated above.							
SIGNATURE <u>H. L. Lillard</u>				M.D. <u>1200 W. 12th</u>		DATE SIGNED <u>11 Jan 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 13-56</u>		NAME OF CEMETERY OR CREMATORY <u>Centra</u>		LOCATION (City, town, or county) (State) <u>Forest Hill MD</u>	
24. REC'D BY REGISTRAR DATE <u>1-14-56</u>		REGISTRAR'S SIGNATURE <u>Marilla Toward</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Martin Skutumpah</u>		ADDRESS <u>---</u>	

RECEIVED

JAN 17 1966

BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

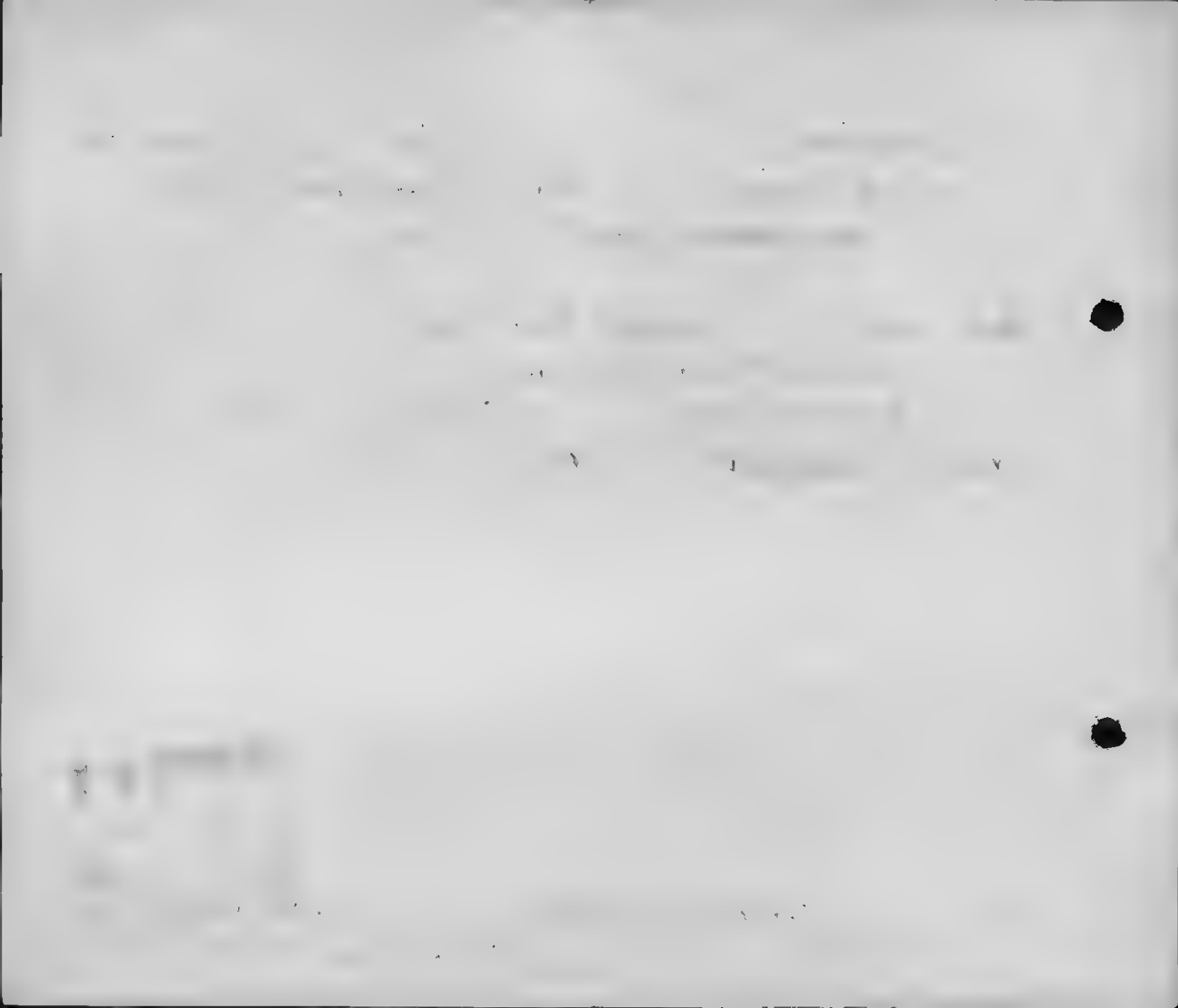
643

00639  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. 1835

<b>1. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Harrods Grace</u>		LENGTH OF STAY (in this place) <u>0 - 06A</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Rural Harrods Grace</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS (If rural, give location) <u>WEBSTER ROAD</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Vivian</u> (Middle) <u>Page</u> (Last) <u>Evans</u>		4. DATE OF DEATH		(Month) (Day) (Year) <u>January 20 1956</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>JUNE 27 1894</u>	9. AGE last birthday: <u>61</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>HOSPITAL AID</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>V.A. HOSPITAL</u>		11. BIRTHPLACE (State or foreign country): <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>JAMES J. EVANS</u>				14. MOTHER'S MAIDEN NAME: <u>GENEVRA POLK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u>		(If Yes, give war or dates of service) <u>WORLD WAR I 214-26-7602</u>		17. INFORMANT & ADDRESS: <u>JOHN M. EVANS HARRODS GRACE MD.</u>			
<b>18. MEDICAL CERTIFICATION</b>							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
42011 Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>Lewell C Palmer</u> M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1/20/56</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>JAN 22 '56</u>		NAME OF CEMETERY OR CREMATORY <u>MT. ZION</u>		LOCATION (City, town, or county) (State) <u>HARFORD Co. MD.</u>	
DATE REC'D BY LOCAL REG <u>JAN. 22 - 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>R. MADISON</u>		ADDRESS <u>MT. ZION HARRODS GRACE MD.</u>	





1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00640

Item 21 Film G192 2-2-56

642

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH COUNTY <u>HARFORD</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whiteford</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD Mem. Hosp.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>HARFORD</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whiteford</u> STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Valley MAY FIZER</u> (First) (Middle) (Last)			4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 17, 1956</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>11/25/1889</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Va.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Avord Keese</u>				
14. MOTHER'S MAIDEN NAME			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)				
16. SOCIAL SECURITY NO.			17. INFORMANT & ADDRESS <u>Howard Fizer - Whiteford, Md.</u>				
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Pneumonia &amp; Malnutrition</u> ANTECEDENT CAUSE(S) DUE TO <u>Fractured Hips -</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>Decubitus ulcers</u> STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>NO</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.) <u>Home</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Whiteford Harf. Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>10-19-55</u> M. <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21e. HOW DID INJURY OCCUR? <u>Slipped while going to bathroom</u>					
22. I hereby certify that I attended the deceased from <u>12-22, 1955</u> to <u>1-17, 1956</u> , that I last saw the deceased alive on <u>1-17, 1956</u> , and that death occurred at <u>1:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. K. Brudner</u> M.D.		DATE SIGNED <u>Harford, Md. 1-18-56</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1/20/56</u>		NAME OF CEMETERY OR CREMATORY <u>State Rd.</u>			
24. REC'D BY REGISTRAR <u>Jan. 20-1956</u>		REGISTRAR'S SIGNATURE <u>U. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkness</u>			
ADDRESS <u>Delta, York Co., Pa.</u>		ADDRESS <u>Delta, Pa.</u>					



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00641

845

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harford</u>		<u>8 days</u>		TOWN <u>Baltimore</u>		<u>31</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>2037 E. Baltimore St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Howell</u> (Middle) (Last) <u>Fuller</u>				(Month) (Day) (Year) <u>Jan. 10 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1904 01</u>	9. AGE last birthday <u>51</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Glen L. Martin</u>	11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Edward A. Fuller</u>				14. MOTHER'S MAIDEN NAME <u>Mary L. Watson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>2 days</u>	
IMMEDIATE CAUSE (A) <u>Fracture skull</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>1/8/56 1:30 P</u>		<u>Harford Road</u>		<u>Fallston Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Auto accident - auto - auto type</u>			
22. I hereby certify that I attended the deceased from <u>January 8, 1956</u> , to <u>January 10, 1956</u> , that I last saw the deceased alive on <u>Jan. 10, 1956</u> , and that death occurred at <u>8:55 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Gerald C Palmer</u>				ADDRESS (Street, city, town, state) <u>Deputy Medical Examiner 1/10/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				DATE THEREOF <u>Jan 13/56</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cem</u>	
24. REC'D BY REGISTRAR <u>Dr. R. L. Lewis</u>				REGISTRAR'S SIGNATURE		LOCATION (City, town, or county) (State) <u>Bolton County</u>	
DATE <u>1/10/56</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Weber</u>		ADDRESS <u>4015 Chester St.</u>	

BUREAU V. S.

JAN 17 1911

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

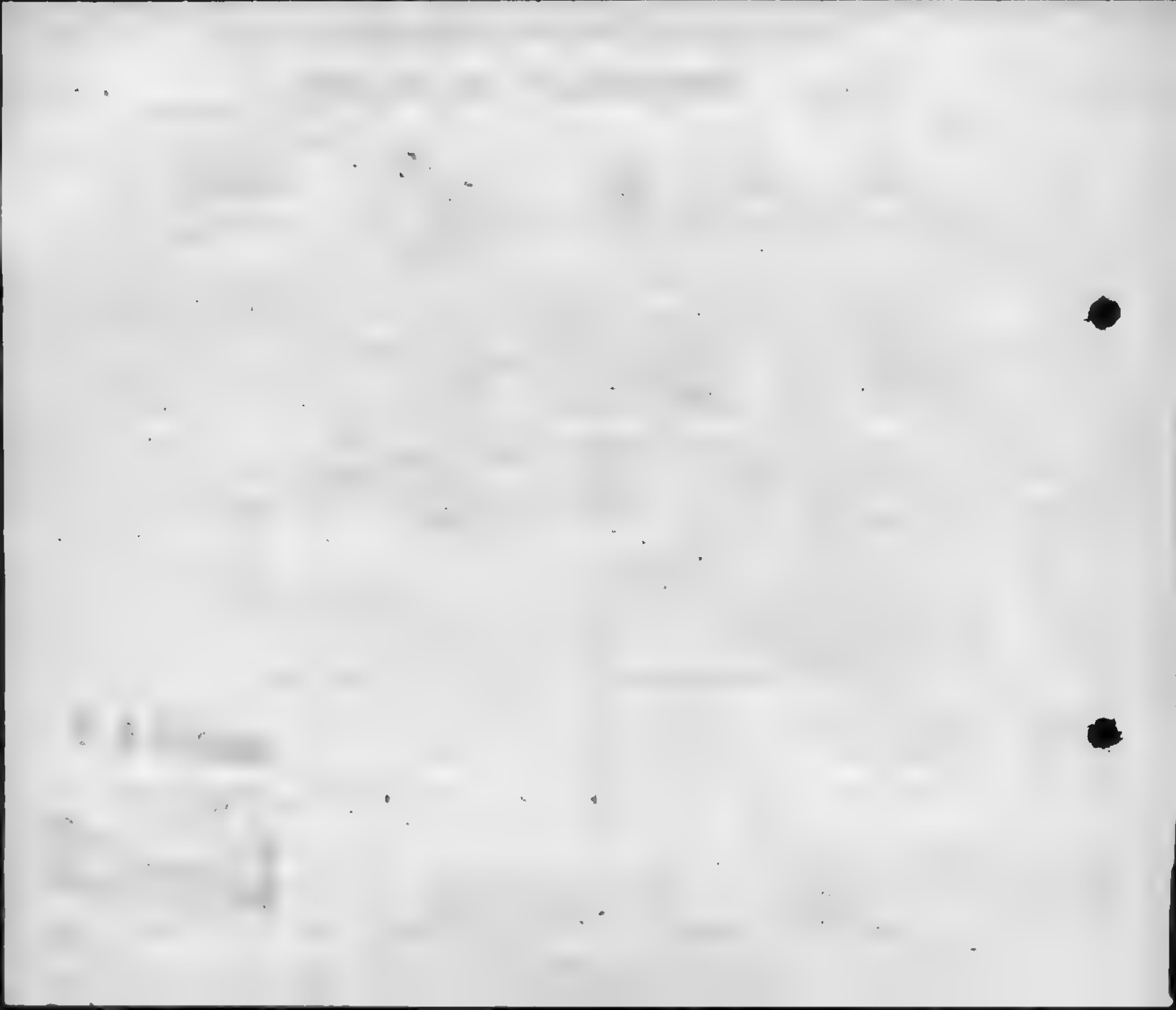
00642

646

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Harford</i>	MARYLAND	STATE <i>MD</i>	COUNTY <i>Harford</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <i>Harwick Grove Rural</i>		TOWN <i>Harwick Grove</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	<i>Rural</i>
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<i>John Lee Gardner</i>		<i>Jan 30 1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Mar 17 1862</i>
9. AGE last birthday <i>93</i> yrs.		10. IF UNDER 1 YEAR	
		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming cattle raised</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cattle</i>	
11. BIRTHPLACE (State or foreign country) <i>Carroll Co, Md</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Gardner - W. Gardner</i>		14. MOTHER'S MAIDEN NAME <i>Mary Gunsenbury</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>	
17. INFORMANT'S ADDRESS <i>John Lee Gardner</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
4. IMMEDIATE CAUSE (A) <i>Myocardial Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>City</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan 30, 1956</i> , to <i>Jan 30, 1956</i> , that I last saw the deceased alive on <i>Jan 30, 1956</i> , and that death occurred at <i>2:15</i> M., from the causes and on the date stated above.			
SIGNATURE <i>H. Snodgrass</i>		DATE SIGNED <i>Feb 2 1956</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		NAME OF CEMETERY OR CREMATORY <i>Rock Run On</i>	
24. REC'D BY REGISTRAR <i>Benjamin B. Knight</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>H. Snodgrass</i>	
REGISTRAR'S SIGNATURE		ADDRESS <i>Rock Run On</i>	
DATE <i>Feb 1 1956</i>			



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-35 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

670

## CERTIFICATE OF DEATH

00643

180

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Magnolia</u>		<u>Lifetime</u>		TOWN <u>Magnolia</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Jerry</u> (Middle) <u>A.</u> (Last) <u>Gilbert</u>				(Month) <u>Jan.</u> (Day) <u>16</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>male</u>	<u>colored</u>	<u>widowed</u>	<u>Dec. 24, 1885</u>	<u>70</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Stationary Fireman</u>		<u>U.S. Govt.,</u>		<u>Magnolia, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Gilbert</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u> (If Yes, give war or dates of service)		<u>213-18-01309 A</u>		<u>Annie Harris, Magnolia, Md.,</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
4. IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>5 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C) <u>Hypertensive Cardiovascular disease</u>						<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/11</u> , 19 <u>56</u> , to <u>1/15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/15</u> , 19 <u>56</u> , and that death occurred at <u>5:00A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George J. Stansbury</u>				ADDRESS (Street, city, town, state) <u>569 Revolution St. Howard de Grace, Md.</u>			
DATE <u>1/15</u> , 19 <u>56</u>				DATE SIGNED <u>1/16/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan. 19, 1956</u>		<u>Magnolia Methodist</u>		<u>Magnolia, Harford, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Jan. 18, 1956</u>		<u>Norma E. Moore</u>		<u>Howard K. Mc Comas &amp; Son</u>		<u>Abingdon, Md.</u>	

BUREAU V. S.

JAN 19 1956

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

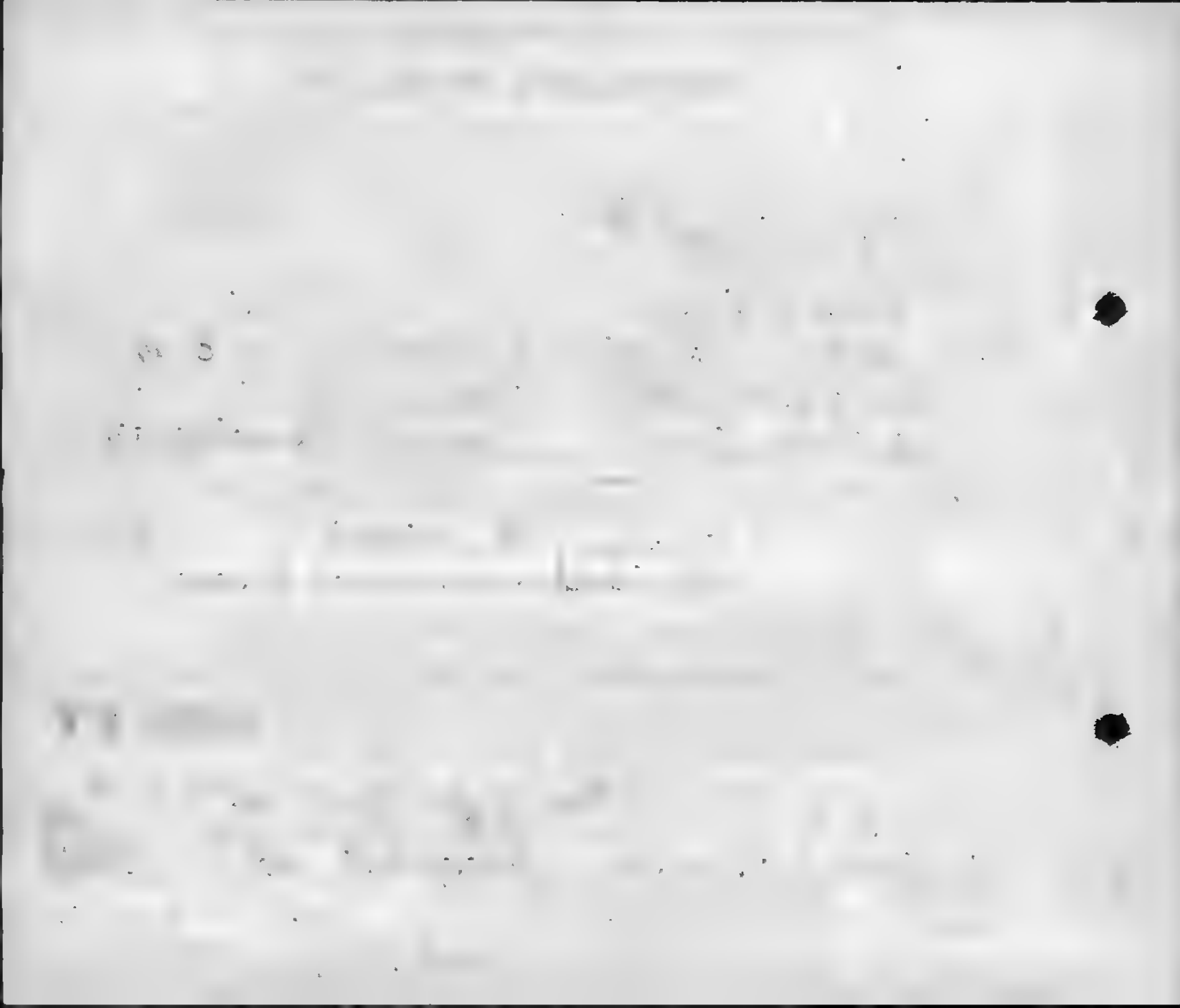
00644

## CERTIFICATE OF DEATH

Item 9, Film G192 2-15-56 et

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Bel Air (Rural)</u>		<u>146 mos</u>		TOWN <u>Bel Air (Rural)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>County Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>John W. Grant</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 31 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Jan 14 1888</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool &amp; Stencil Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		9. AGE last birthday <u>67</u> yrs. <u>6</u> months <u>14</u> days		11. BIRTHPLACE (State or foreign country) <u>Upper X Roads Harford Co Md</u>	
13. FATHER'S NAME <u>William Grant</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME <u>Margaret Cunningham</u>		16. SOCIAL SECURITY NO. <u>0310 York Rd</u>	
18. MEDICAL CERTIFICATION				17. INFORMANT & ADDRESS <u>Mrs Catherine Martin Bel Air</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				3 days			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chr Cardio-Vascular Disease</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1 1950</u> to <u>Jan 31 1956</u> , that I last saw the deceased alive on <u>1-30-56</u> 19 <u>56</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D.				DATE SIGNED <u>2-1-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb 2-56</u>		NAME OF CEMETERY OR CREMATORY <u>St Johns</u>		LOCATION (City, town, or county) (State) <u>Hyde Balt Co Md</u>	
24. REC'D BY REGISTRAR <u>2-3-56</u>		REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Marion Skutz</u> ADDRESS <u>Janetville Md</u>			



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00645

647

## CERTIFICATE OF DEATH

Reg. Dist. No. 180-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>HAVER DE GRACE</u>		LENGTH OF STAY (in this place) <u>21 HRS</u>		TOWN <u>HAVER DE GRACE</u>		STREET ADDRESS (If rural give location) <u>561 GREEN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL Hosp.</u>							
3. NAME OF DECEASED (Type or Print) <u>Edward Frank Hansell</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 1 19 56</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>July 22, 1890</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Storekeeper - Saw Works Shop</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <u>65</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Joseph Hansell</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-03-0984</u>		17. INFORMANT & ADDRESS <u>VIRGINIA A. HANSELL-HAVER DE GRACE MD.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Cardiac</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Hypertensive Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Coronary Thrombosis</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/1</u> , 19 <u>56</u> , to <u>1/1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/1</u> , 19 <u>56</u> , and that death occurred at <u>11</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Charles J. Foley M.D.</u>				ADDRESS (Street, city, town, state) <u>1400 W. 11th St. Md.</u> DATE SIGNED <u>1/1/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-4-1956</u>		NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>		LOCATION (City, town, or county) (State) <u>HAVER DE GRACE, MD.</u>	
24. REC'D BY REGISTRAR <u>Jan. 3-1956</u>		REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>HAVER DE GRACE, MD.</u>	

1 m 22, 1891

Revised edition of - 2nd edition

217 63-0784 1 m 22, 1891

AN 2

1 m 22, 1891

672

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

COUNTY **HARFORD**

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

X TOWN **RURAL-STREET**

LENGTH OF STAY (in this place)

**22 yrs.**

HOSPITAL OR INSTITUTION OR STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **MD.**COUNTY **HARFORD**

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN **Rural - Street**

STREET ADDRESS (If rural give location)

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

**Edgar Routzahn Hauer**

4. DATE (Month)

(Day)

(Year)

OF DEATH: **JAN. 17, 1956**

## 5. SEX

**M**

## 6. COLOR OR RACE:

**W**

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

**Married**

## 8. DATE OF BIRTH:

**Sept 19, 1887**

## 9. AGE last birthday

**68** yrs.

## IF UNDER 1 YEAR

## IF UNDER 24 HRS.

Months

Days

Hours

Min.

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Teacher**

## 10B. KIND OF BUSINESS OR INDUSTRY:

**Public Schools**

## 11. BIRTHPLACE (State or foreign country):

**Myersville, Md.**

## 12. CITIZEN OF WHAT COUNTRY?

**U.S.A.**

## 13. FATHER'S NAME:

**Thaddeus Hauer**

## 14. MOTHER'S MAIDEN NAME:

**Charlotte Routzahn**

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

**yes****W.W.I**

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

**Helen E. Hauer, Street, Md.**

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**22**

## IMMEDIATE CAUSE

(A)

**Cerebral Hemorrhage**

DUE TO

## ANTECEDENT CAUSE (S)

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO

**Arteriosclerotic cerebro-vascular renal disease**

(C)

## INTERVAL BETWEEN ONSET AND DEATH

**5 mo.**

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

**Congestive Heart Failure****2 wks.**

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☐

## 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

## 21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

## 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐

M.

at work ☐ at work ☐

## 21F. HOW DID INJURY OCCUR?

## 22. I hereby certify that I attended the deceased from May 5, 1951, to Jan. 17, 1956, that I last saw the deceased

alive on Jan. 16, 1956, and that death occurred at 1:30 A.M. from the causes and on the date stated above.

SIGNATURE

**Charles C. Druff**

ADDRESS

**Street, Md.**

DATE SIGNED

**Jan. 18, 1956**

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

**BURIAL**

## DATE THEREOF

**JAN. 19, 1956**

## NAME OF CEMETERY OR CREMATORY

**BELAIR GARDENS**

## LOCATION (City, town, or county)

**BELAIR, MD.**

## DATE REC'D BY LOCAL REGISTRAR

**1-19-56**

## REGISTRAR'S SIGNATURE

**Pravilla Lowwood**

## 24. FUNERAL DIRECTOR

## ADDRESS

**John H. Harkins, Delta, Pa.**

MARGIN RESERVED FOR BINDING

1

1000

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

043

## CERTIFICATE OF DEATH

00647

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>HARFORD</u>			
CITY OR TOWN <u>Harre de Grace</u>		LENGTH OF STAY (in this place) <u>4 days</u>		CITY OR TOWN <u>Aldie</u>		RD <u>2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD Memorial Hosp.</u>				STREET ADDRESS <u>Aberdeen, Md</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Charles</u> (First) <u>Herpel</u> (Last)				4. DATE OF DEATH <u>January 5</u> 19 <u>56</u> (Month) (Day) (Year)			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Jan 1st. 1880</u>	9. AGE last birthday <u>76</u> Yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired laborer.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Day laborer.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown.</u>				14. MOTHER'S MAIDEN NAME <u>Unknown.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Marion Presner, R. 2 Aberdeen Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
177X IMMEDIATE CAUSE (A) <u>Cerebral Prostate</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>General Cardiovascular</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cerebral</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1, 1956</u> to <u>Jan 5, 1956</u> , that I last saw the deceased alive on <u>1/5</u> , 19 <u>56</u> , and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles J. Foley</u>				ADDRESS (Street, city, town, state) <u>Harre de Grace Md</u>		DATE SIGNED <u>1/5/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 8-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Churchville Presbyterian</u>		LOCATION (City, town, or county) (State) <u>Churchville Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>L. Lewis M. H.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Garring</u>		ADDRESS <u>Aberdeen Md.</u>	
DATE <u>Jan. 9-1956</u>							





1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01829

673

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

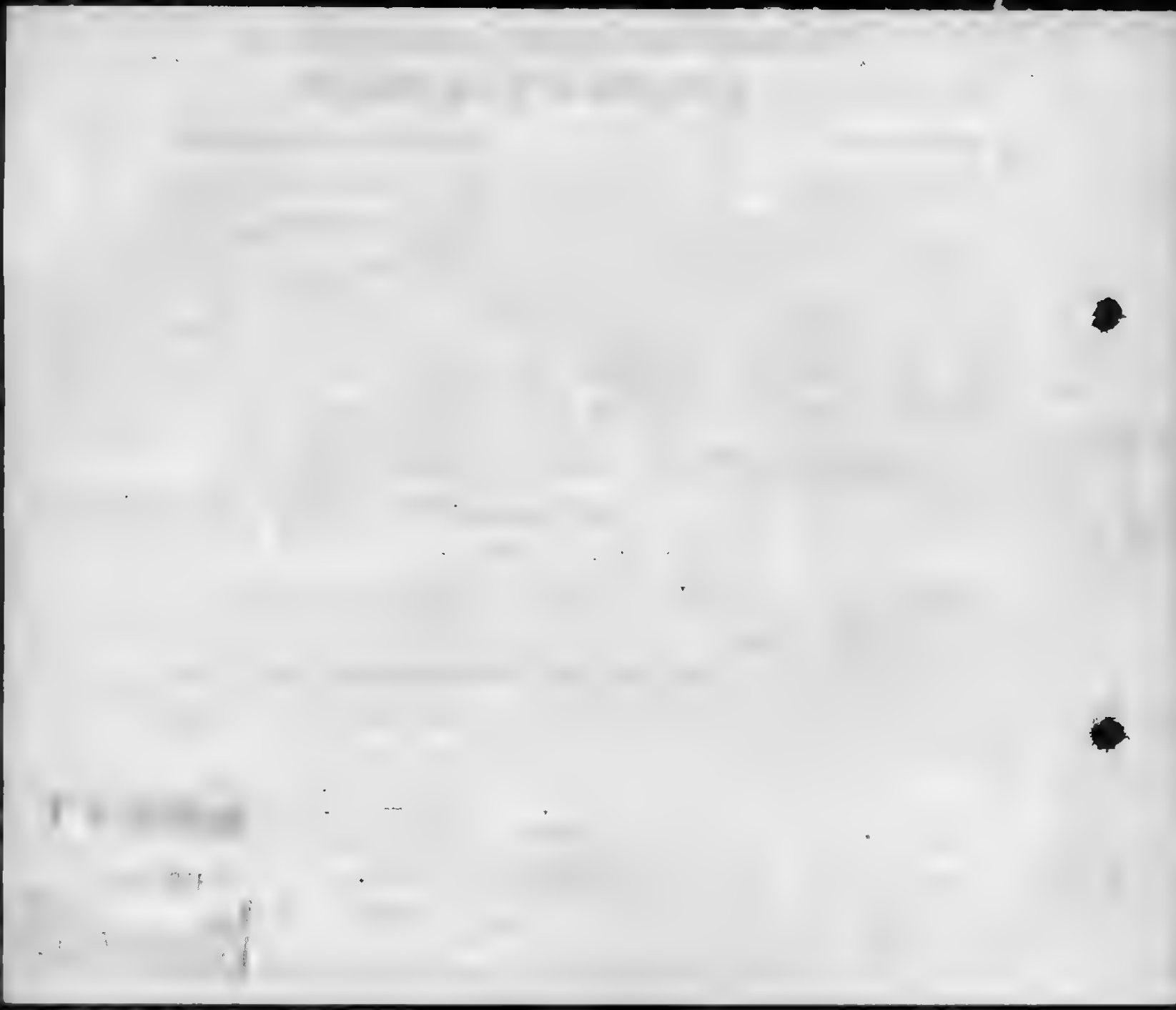
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Beltier Rural</u>				TOWN <u>Aberdeen</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Conv. Home.</u>				STREET ADDRESS (If rural give location) <u>335 Law Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Ellen</u> (Middle) <u>F.</u> (Last) <u>HIPKINS</u>				(Month) <u>Jan</u> (Day) <u>30</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Unmarried</u>	8. DATE OF BIRTH <u>Feb 16th 1873</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home.</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Henry Preston</u>				14. MOTHER'S MARDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT & ADDRESS <u>Virginia M. Goetz - Aberdeen Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute cerebral hemorrhage</u>				?			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chr. cardio-vascular disease</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 5</u> , 19 <u>52</u> , to <u>Feb. Jan. 30</u> , 1956, that I last saw the deceased alive on <u>Jan. 29</u> , 19 <u>56</u> , and that death occurred at _____ M., from the causes and on the date stated above							
SIGNATURE <u>Willard P. Hudson</u>				ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>Jan. 31, 1956</u>			
23. BURIAL, CREMATON, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>2/3/56</u>	NAME OF CEMETERY OR CREMATORY <u>Wesleyan Chapel Cemetery</u>		LOCATION (City, town, or county) <u>Aberdeen Md.</u>		(State)	
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>Priscilla Lowndes</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Fanning</u>		ADDRESS <u>Aberdeen Md.</u>			
DATE <u>2-7-56</u>							

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

649

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00648

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>			
CITY OR TOWN <u>Hare-de-Groce</u>		LENGTH OF STAY (in this place) <u>7 hrs.</u>		CITY OR TOWN <u>Darlington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>		STREET ADDRESS (If rural give location)					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARY</u> (Middle) <u>JAMES.</u> (Last)				1 - 15 - 1956			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>March 17, 1932</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife at Harford</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Smith</u>				14. MOTHER'S MAIDEN NAME <u>Cassandra Bird</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>Willard Smith</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Arterio-sclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO <u>Cardio-vascular Hyper</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>Arterio-sclerosis</u>							
STATING UNDERLYING CAUSE LAST. DUE TO <u>Cerebral Hemorrhage</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 15, 1956</u> to <u>Jan 15, 1956</u> , that I last saw the deceased alive on <u>Jan 15, 1956</u> , and that death occurred at <u>9:55 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles J. Felt</u>				ADDRESS (Street, city, town, state) <u>Harford Memorial Hospital</u>		DATE SIGNED <u>1/15/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 18, 1956</u>		<u>Wardington Cem</u>		<u>Harford Co, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Jan 24, 1956</u>		<u>W. B. Lewis</u>		<u>W. B. Lewis</u>		<u>Wardington Md</u>	

JAN 11 1960

JAN

11 1960

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO PUBLIC HEALTH DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00649

650

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HAVRE DE GRACE</u>		<u>LIFE</u>		TOWN <u>HAVRE DE GRACE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>735 ONTARIO ST.</u>				STREET ADDRESS (If rural give location) <u>735 ONTARIO ST.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARY ETTA GIBSON JOES</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 11 1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>FEB. 8, 1872</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES GIBSON</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE E. CALLWELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>MRS. W. M. S. JOHNSON</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Senile Debility</u>				ANTECEDENT CAUSE(S) DUE TO <u>Cardio Vascular Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u>Cardio Vascular Disease</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/4</u> 19 <u>54</u> to <u>1-10</u> 19 <u>56</u> , that I last saw the deceased alive on <u>1-10</u> 19 <u>56</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Havre de Grace, Md.</u>		DATE SIGNED <u>1-12-56</u>	
23. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>JAN. 14 1956</u>		NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM</u>		LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P. MADISON MITCHELL</u>		ADDRESS <u>HAVRE DE GRACE, MD.</u>	
DATE <u>Jan. 12-1956</u> - <u>C. L. Lewis</u>							

1990

700

200

1940

$\frac{1}{2} \times 10 = 5$

1900 1901 1902 1903 1904 1905 1906 1907 1908 1909 1910 1911 1912 1913 1914 1915 1916 1917 1918 1919 1920 1921 1922 1923 1924 1925 1926 1927 1928 1929 1930 1931 1932 1933 1934 1935 1936 1937 1938 1939 1940 1941 1942 1943 1944 1945 1946 1947 1948 1949 1950 1951 1952 1953 1954 1955 1956 1957 1958 1959 1960 1961 1962 1963 1964 1965 1966 1967 1968 1969 1970 1971 1972 1973 1974 1975 1976 1977 1978 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718

22 17 234 / 2 3 1 8 11

RECEIVED ZENITH

[illegible]

THE UNIVERSITY OF CHICAGO

2000 年 12 月 15 日

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AHC 1-55 104

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

051

## CERTIFICATE OF DEATH

00650

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harford, Md</u>		<u>5 days</u>		TOWN <u>Edgewood</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Theresa Laurine P Jones</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 2 1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept. 21, 1924</u>	9. AGE last birthday <u>31</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock Clerk</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>	11. BIRTHPLACE (State or foreign country) <u>Penna</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>		
13. FATHER'S NAME <u>James Peltier</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-22-8940</u>		17. INFORMANT & ADDRESS <u>Kenneth E. Jones, Jr., Edgewood, R.D. Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Tetanus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Intestinal obstruction</u>				<u>5 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Volvulus secondary to multiple adhesions.</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pneumonia - Septicemia</u>				<u>36 hrs.</u>			
19a. DATE OF OPERATION <u>Dec. 31, 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Pelvic abscess drained through Cul-de-sac</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 27, 1955</u> , to <u>Jan. 2, 1956</u> , that I last saw the deceased alive on <u>Jan. 1, 1956</u> , and that death occurred at <u>10:25 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William A. Tyson</u> M.D.				ADDRESS (Street, city, town, state) <u>Kingsville, Md.</u>		DATE SIGNED <u>Jan. 2, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 5, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		LOCATION (City, town, or county) (State) <u>Bel Air, Harford Md.</u>	
24. REC'D BY REGISTRAR <u>Jan 5-1956</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas &amp; Son</u>		ADDRESS <u>Abingdon, Md.</u>	

U. S.



1

INSTRUCTIONS

1

**TO ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

352

## CERTIFICATE OF DEATH

00651

Reg. Dist. No. 185-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u> <u>Maryland</u> <u>MARYLAND</u>				STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)				CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harde Chase</u>				TOWN <u>Harde Chase</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>729 Ontario</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Hila</u> (Middle) <u>Burlin</u> (Last) <u>Leatley</u>				(Month) <u>1/24</u> (Day) <u>56</u> (Year) <u>19</u>			
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH</b>	
<u>Female</u>		<u>White</u>		<u>Widow</u>		<u>1/24/1883</u>	
<b>9. AGE last birthday</b>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)	
<u>74</u> yrs.		<u>House Wife</u>		<u>—</u>		<u>Port Deposit, Md</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b>		<b>13. FATHER'S NAME</b>		<b>14. MOTHER'S MAIDEN NAME</b>			
<u>U.S.A.</u>		<u>Samuel O. Burlin</u>		<u>Mary E. Carroll</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
<u>Yes</u>				<u>Unknown</u>		<u>Boothby H. Evans Jr</u> <u>729 Ontario</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>1. IMMEDIATE CAUSE (A)</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>Pulmonary Oedema</u>						<u>1 day -</u>	
<b>2. ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>						<u>6 days -</u>	
<b>STATING UNDERLYING CAUSE LAST, DUE TO</b>							
<b>(C)</b>						<u>10 years -</u>	
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County)</b> <b>(State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>June</u>, 19<u>58</u> to <u>Jan 24</u>, 19<u>56</u>, that I last saw the deceased alive on <u>1/24/56</u>, 19<u>56</u>, and that death occurred at <u>2 A</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b> <b>(State)</b>	
<u>Mark Wehrh M.D.</u>		<u>1/26/56</u>		<u>Angel Hill</u>		<u>Harde Chase Md.</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>24. REC'D BY REGISTRAR</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>Removal</u>		<u>1/26/56</u>		<u>Harde Chase Maryland</u>		<u>Jan 26 1956</u>	
<b>DATE</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>ADDRESS</b>			
<u>Jan 26 - 1956</u>		<u>Li. L. Lewis M.D.</u>		<u>Harde Chase Md.</u>			



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00652

653

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH COUNTY <u>Hartford</u> CITY OR TOWN <u>Havre de Grace</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Mem. Hosp.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u></u> CITY OR TOWN <u>Havre de Grace</u> STREET ADDRESS <u>R.D.#2 Earleton Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>Mildred M. Kelly</u>				4. DATE OF DEATH <u>JAN 18 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>9/27/1895</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>LUCIEN McLEAN</u>				14. MOTHER'S MAIDEN NAME <u>Elsie Gibson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NC</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT & ADDRESS <u>Clyde J. Kelly, Jr. - R.D.#2 Earleton Rd. Havre de Grace</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4. IMMEDIATE CAUSE (A) <u>Cardiac Failure &amp; Decompensation</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Rheumatic Heart Disease and atherosclerotic Cardiovascular disease</u>						years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>							
19a. DATE OF OPERATION <u>No</u>		19b. MAJOR FINDINGS OF OPERATION <u></u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office-bldg., etc.) <u></u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u></u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u></u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>July 15th, 1954</u> to <u>Jan 18th, 1956</u> that I last saw the deceased alive on <u>Jan 18th, 1956</u> and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>JAN 19 1956</u>		NAME OF CEMETERY OR CREMATORY <u>MOUNT LAWN CEM. WAKE CO.</u>		LOCATION (City, town, or county) (State) <u>N.C.</u>	
24. REC'D BY REGISTRAR <u>Jan 18-1956</u>		REGISTRAR'S SIGNATURE <u>G. J. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madman</u>		ADDRESS <u>211 N. Union Ave. Havre de Grace, Md. 21118</u>	

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

## CERTIFICATE OF DEATH

Reg. Dist. No. 180

Item 9, Film G191 1-16-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Starford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Starford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Abingdon, Md.</u>				STREET OR TOWN <u>Street, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 7</u>				STREET ADDRESS (If rural give location) <u>R. F. D. #1</u>			
3. NAME OF DECEASED (Type or Print) <u>Ernest Walter Lee</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>January 5 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1-12-1903</u>	9. AGE last birthday <u>52</u> <u>HY</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Munition Handler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Army Chemical Center</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Lee</u>				14. MOTHER'S MAIDEN NAME <u>Mrs. V. Williamson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-07-9578</u>		17. INFORMANT & ADDRESS <u>Mrs. Anna Lee - Street, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Asph, xia, accidental due to</u>		DUE TO <u>drowning following auto</u>				-	
ANTECEDENT CAUSE(S) (B) <u>accident</u>		DUE TO <u>accident</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C) <u>accident</u>		DUE TO <u>accident</u>					
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Route 7</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Abingdon Harb. Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>Jan. 5, 1956 8:30 P. M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> <u>at work</u> <u>at work</u>		21f. HOW DID INJURY OCCUR? <u>Auto accident, auto - auto type</u>			
22. I hereby certify that I attended the deceased from ..... 19....., to ..... 19....., that I last saw the deceased alive on ..... 19....., and that death occurred at ..... M., from the causes and on the date stated above.							
SIGNATURE <u>Ronald C Palmer</u>				ADDRESS (Street, city, town, state) <u>Deputy Medical Examiner 1/6/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-10-56</u>		NAME OF CEMETERY OR CREMATORY <u>Clark's Chapel Church</u>		LOCATION (City, town, or county) (State) <u>Palmer - Starford C. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Norma G. Moore</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Otis J. Bullock</u>		ADDRESS <u>Harb. Md.</u>	
DATE <u>Jan 8, 1956</u>							

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be filed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

354

## CERTIFICATE OF DEATH

00654

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAVRE DE GRACE</u>		LENGTH OF STAY (in this place) <u>LIFE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAVRE DE GRACE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>709 MARKET, ST.</u>				STREET ADDRESS (If rural give location) <u>709 MARKET, ST</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>ROTH</u> (First) <u>BROADWATER</u> (Middle) <u>LOTZ</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>JAN</u> (Day) <u>29</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>DIVORCED</u>	<b>8. DATE OF BIRTH</b> <u>DEC 14 1908</u>	<b>9. AGE last birthday</b> <u>47</u> yrs.	<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>TELEPHONE OPERATOR.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>C.P. JEL</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MD</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>DANIEL BROADWATER</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>EMMA WILSON</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>—</u>		<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>EMMA W.B. BAKER - HAVRE DE GRACE, MD.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>151X IMMEDIATE CAUSE (A)</b> <u>Cerebral Anemia</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>General Cerebral Anemia</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b> <u>Chronic</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Sept 1, 1952</u>, to <u>Jan 29, 1956</u>, that I last saw the deceased alive on <u>Jan 29, 1956</u>, and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Charles J. Foley M.D.</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Harford Ave 1/30/56</u>		<b>DATE SIGNED</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>JAN 30-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>ANGEL HILL CEM</u>		<b>LOCATION (City, town, or county) (State)</b> <u>HAVRE DE GRACE, MD.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Jan 31-1956</u>		<b>REGISTRAR'S SIGNATURE</b> <u>W. L. Lewis M.D.</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>R. Madison Mitchell</u>		<b>ADDRESS</b> <u>HAVRE DE GRACE, MD.</u>	

RECEIVED

FEB 1 1956

BUREAU V. S.



**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 155 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00655

655

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		STATE <u>Maryland</u>		COUNTY <u>Hartford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harrods Grace</u>		LENGTH OF STAY (In this place) <u>Y.O.H.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural #1</u>			
TOWN <u>Harrods Grace</u>				TOWN <u>Aberdeen Rural #1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Memorial</u>				STREET ADDRESS (If rural give location) <u></u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Gilbert</u> (Middle) <u>Clay</u> (Last) <u>Wabe</u>				(Month) <u>January</u> (Day) <u>5</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 7th 1922</u>	9. AGE last birthday <u>33</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe factory</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wiley Arthur Wabe</u>				14. MOTHER'S MAIDEN NAME <u>Floora Farris Phouts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>246-22-2930</u>		17. INFORMANT & ADDRESS <u>W. Edison Wabe, Belcamp, Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Fracture skull</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Auto</u>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Home</u>		21c. WHERE DID INJURY OCCUR? (City or town) <u>Aberdeen</u> (County) <u>Hartford</u> (State) <u>Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Jan 5 1956 8:30 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Auto accident auto-auto type</u>			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M., from the causes and on the date stated above.							
SIGNATURE <u>James E. Palmer</u>		M.D. <u>Deputy Medical Examiner</u>		ADDRESS (Street, city, town, state) <u></u>		DATE SIGNED <u>1/6/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Jan 9 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Sharon Baptist Cemetery</u>		LOCATION (City, town, or county) <u>Forrest Hill, Maryland</u> (State) <u></u>	
24. REC'D BY REGISTRAR <u>Jan 9 1956</u>		REGISTRAR'S SIGNATURE <u>U. L. Lewis M. D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Garrison</u>		ADDRESS <u>Aberdeen Md.</u>	



656

00656  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 185

## 1. PLACE OF DEATH:

COUNTY Harford MARYLAND  
CITY (If outside corporate limits, write RURAL OR and give nearest town) LENGTH OF STAY  
TOWN Harre De Grace 1 day  
HOSPITAL OR INSTITUTION OR STREET ADDRESS DOA Harford Memorial

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE md COUNTY Balto  
CITY (If outside corporate limits write RURAL and give nearest town) OR  
TOWN Long Green  
STREET ADDRESS (If rural, give location)  
Long Green Manor Rd

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

MaryMamma

## 4. DATE OF DEATH

(Month)

(Day)

(Year)

JAN 27, 1956

## 5. SEX:

## 6. COLOR OR RACE:

7. SINGLE, MARRIED, (WIDOWED), DIVORCED, (Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Female  
work done during most of work life, even if retired): Housewife over Home

10b. KIND OF BUSINESS OR INDUSTRY:  
Balto. md

11. BIRTHPLACE (State or foreign country):  
Balto. md

12. CITIZEN OF WHAT COUNTRY?  
USA

## 13. FATHER'S NAME:

Charles E Reinhardt

## 14. MOTHER'S MAIDEN NAME:

Emily A Francis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  
NO

16. SOCIAL SECURITY No.:  
None

## 17. INFORMANT &amp; ADDRESS:

David E Mamma Manor Rd Long Green md

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 hr

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Fracture L. Femur2 hr

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Route 152

21c. (City or town)

(County)

(State)

ForkBaltimore md

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 11/8/56 P.M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

## 21f. HOW DID INJURY OCCUR?

Auto accident auto-auto type

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

## SIGNATURE

Donald C Palmer

M. D.

CHIEF MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAM. ☒

## DATE SIGNED

1/8/56

23. BURIAL, CREMATION, REMOVAL (Specify):  
Burial

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 1/10/56

REGISTRAR'S SIGNATURE  
C. W. Hedrick

## 24. FUNERAL DIRECTOR

Lorraine Funeral Home 7461 Belair Rd

## ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



875

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hubbly</u>				TOWN <u>Hubbly</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
50 <u>Hubbly</u>				<u>Hubbly</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Maie T. McCann</u> (Middle) (Last)				(Month) (Day) (Year)			
				<u>Jan 31, 1956</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>White</u>		<u>Widow</u>		<u>75</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Homemaker</u>		<u>None</u>		<u>Harford Co. Md.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Wm. T. Thompson</u>				<u>Margaret Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS			
<u>No</u>		<u>No</u>		<u>Mrs. Maie T. McCann</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				<u>6 hrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO				<u>4 yrs</u>			
(C)							
17 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>✓</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 31, 1956</u> to <u>Jan 31, 1956</u> , that I last saw the deceased alive on <u>Jan 31, 1956</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. J. E. Kirk</u> M.D.				ADDRESS (Street, city, town, state)		DATE SIGNED <u>2/1/56</u> (State)	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>Jan 3, 1956</u>		<u>Hubbly Co. Md.</u>		<u>Harford Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Feb 1, 1956</u>		<u>C. W. Kirk</u>		<u>Ad. Bailey</u>		<u>Darlington Md.</u>	

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



00657

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

657

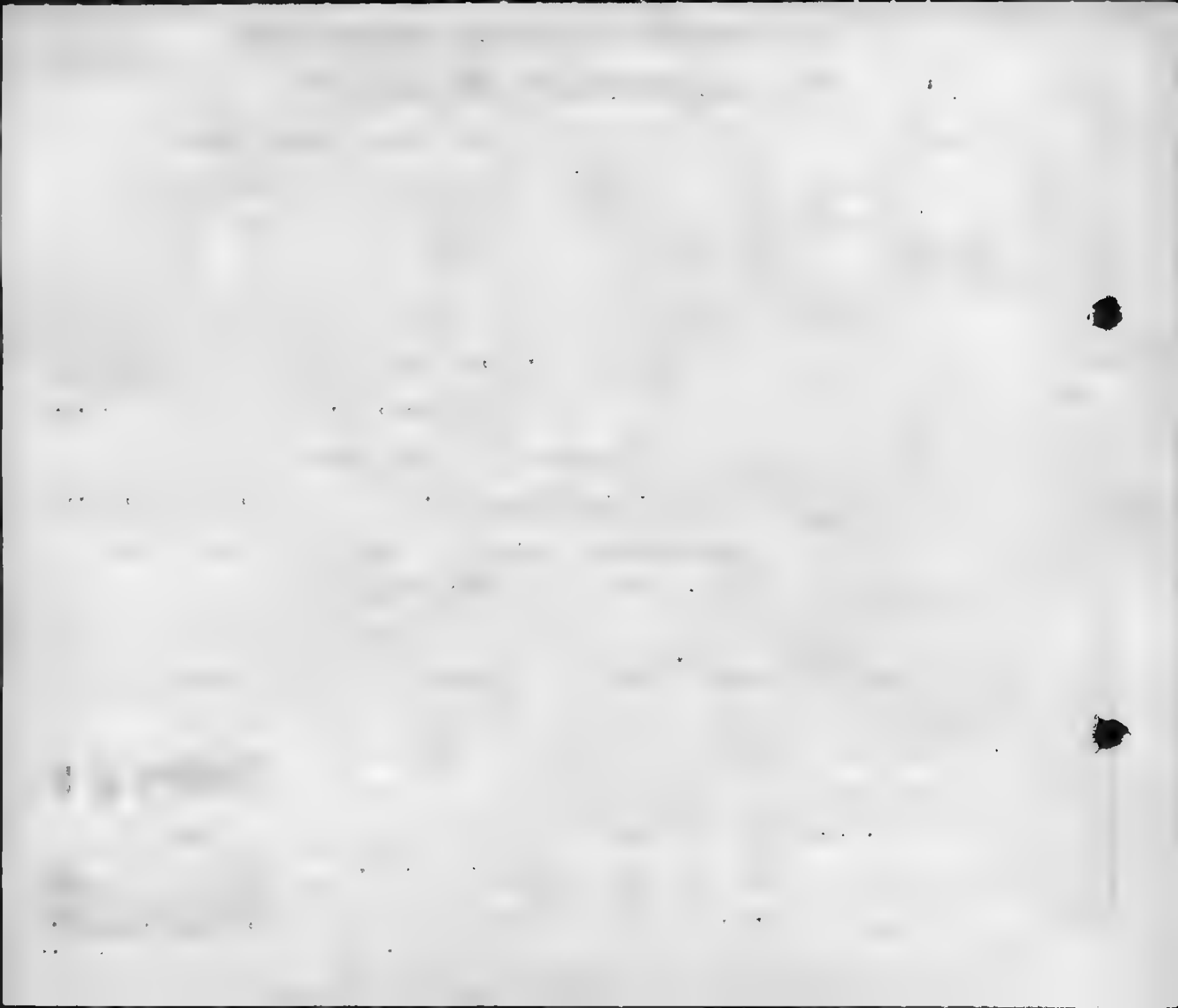
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harford</u>		<u>15 days</u>		TOWN <u>Edgewood</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Martin</u> (Middle) <u>A</u> (Last) <u>Necker</u>				(Month) <u>Jan</u> (Day) <u>15</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 11, 1873</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Track Foreman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.,</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Anna Bunn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>717-07-5425</u>		17. INFORMANT & ADDRESS <u>Mrs. William Fertig, Edgewood, Md.,</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Auricular Fibrillation and Peripheral vascular collapse</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chr. Hypertensive Cardio-vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chr. Prostatism</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1955</u> , to <u>January 15, 1956</u> , that I last saw the deceased alive on <u>Jan. 15, 1956</u> , and that death occurred at <u>9:23 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D. <u>Forest Hill, Md.</u>				DATE SIGNED <u>1-16-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 18, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		LOCATION (City, town, or county) (State) <u>Bel Air, Harford, Md.</u>	
24. REC'D BY REGISTRAR <u>Jan. 17-1956</u>		REGISTRAR'S SIGNATURE <u>T. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas &amp; Son</u> ADDRESS <u>Abingdon, Md.,</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be furnished for use as a burial transit permit.

VS AISC 1-55 10M





658

## CERTIFICATE OF DEATH

Reg. Dist. No. 83-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY OR TOWN <u>Harre de Grace</u>		LENGTH OF STAY (in this place) <u>about 40 yrs.</u>		CITY OR TOWN <u>Harre de Grace</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>517 Girard Street</u>				STREET ADDRESS <u>517 Girard Street</u>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Charlie Price</u>				<b>4. DATE OF DEATH</b> (Month) <u>1</u> (Day) <u>12</u> (Year) <u>19 56</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>Aug 14, 1874</u>	<b>9. AGE last birthday</b> <u>81 yrs.</u>	<b>IF UNDER 1 YEAR</b> Months <u></u> Days <u></u>		<b>IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Contractor</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Brunswick, Va.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Levy Price</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Judy (unknown)</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Rev. Jesse Woolfolk - Harre de Grace</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>422. IMMEDIATE CAUSE (A)</b> <u>Uremia</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Arteriosclerotic Heart Disease</u>							
<b>(C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>12/1/54</u> , 19 <u>56</u> , to <u>1/11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/11</u> , 19 <u>56</u> , and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>George J. Stansbury</u>				<b>ADDRESS</b> (Street, city, town, state) <u>529 Revolution St. Harre de Grace Md.</u>		<b>DATE SIGNED</b> <u>1/13/56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>1-15-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>St. James Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Harre de Grace Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>13-1956</u>		<b>REGISTRAR'S SIGNATURE</b> <u>G. F. Tamm</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur J. Bullock</u>		<b>ADDRESS</b> <u>Harre de Grace Md.</u>	

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00659

676

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		STATE <u>MARYLAND</u>		STATE <u>New York</u>		COUNTY <u>Seneca</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Aberdeen</u>		<u>5 hrs</u>		TOWN <u>Seneca Falls</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>US Army Hospital</u>				STREET ADDRESS (If rural give location)			
<u>Aberdeen Proving Ground</u>				<u>109 Cayuga</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>John</u>		(Middle) <u>Michael</u>		(Last) <u>RALER</u>		(Month) <u>January</u> (Day) <u>20</u> (Year) <u>19 56</u>	
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>10. IF UNDER 1 YEAR</b>		
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>January 20 1956</u>	<u>5</u> yrs.	<u>Months</u>	<u>Days</u>	<u>Hours</u> <u>5</u> <u>Mins.</u> <u>2</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>None</u>		<u>None</u>		<u>Maryland</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Burton Ramer</u>				<u>Susanna Knight</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>0</u>		<u>-</u>		<u>Father - as in 2</u>			
<b>18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>19. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Erythroblastosis fetalis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
<b>20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town)		(County) (State)	
<input type="checkbox"/>							
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Jan 20, 19 56, to Jan 20, 19 56, that I last saw the deceased alive on Jan 20, 19 56, and that death occurred at 2:50 PM, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<u>Herndon Leguizamon Capt MC</u>				<u>Jan 23 1956</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>24. REC'D BY REGISTRAR</b>			
<u>Burial</u>				<u>Jan 25 1956</u>			
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>				<b>26. ADDRESS</b>			
<u>John G. Tarring</u>				<u>Aberdeen Proving Ground, Md</u>			
<b>27. REGISTRAR'S SIGNATURE</b>				<b>28. ADDRESS</b>			
<u>Phillip R Perry</u>				<u>Army Chemical Center Md</u>			
<b>29. DATE</b>				<b>30. ADDRESS</b>			
<u>Jan 24-56</u>				<u>Aberdeen Md</u>			



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be filed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10A

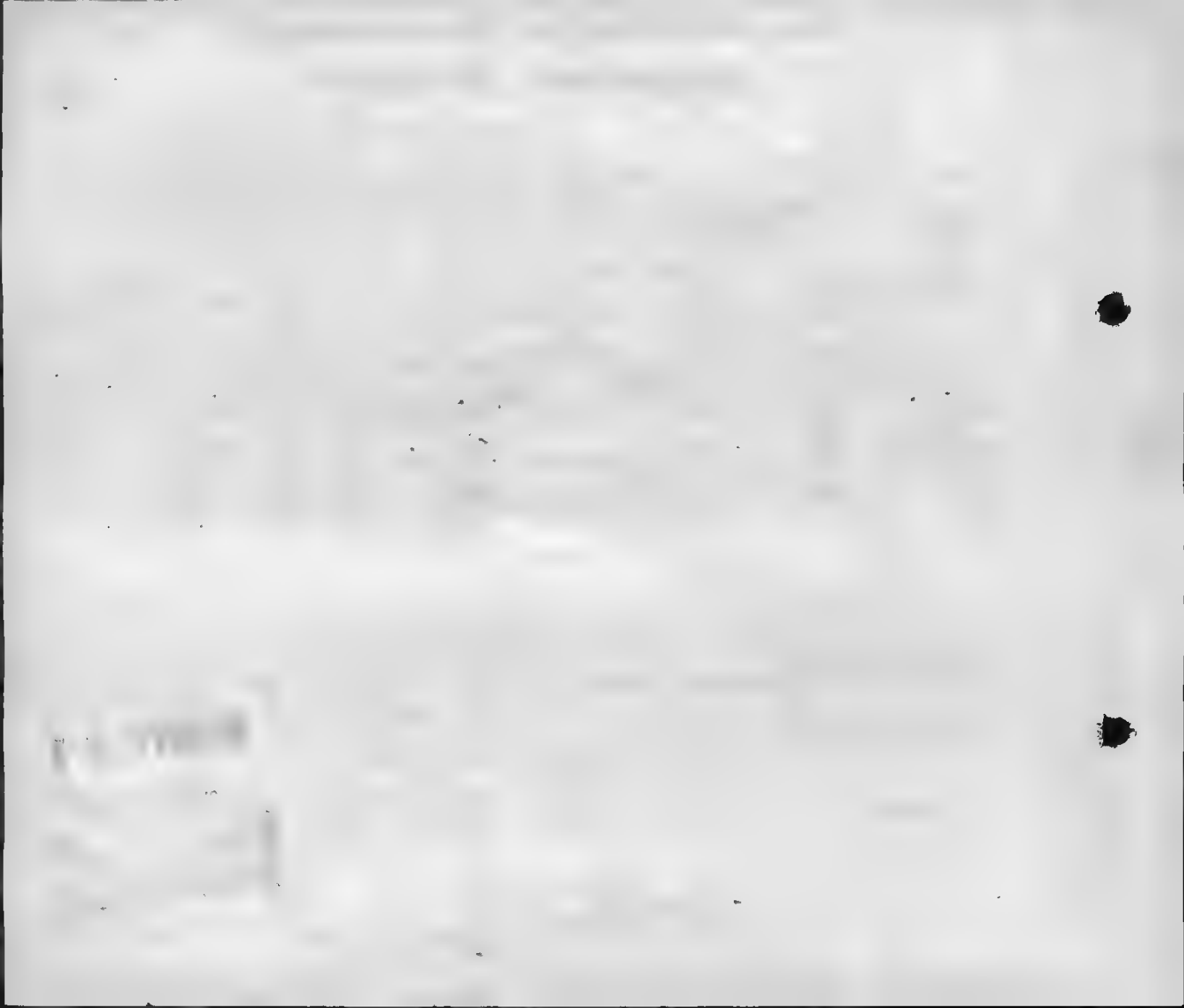
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00660

677  
CERTIFICATE OF DEATH

Reg. Dist. No. 186

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Oliver H.</u> (Middle) <u>Smith</u> (Last)				(Month) <u>Jan</u> (Day) <u>7</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>March 26, 1865</u>	<u>90</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>None</u>		<u>Harford Co. Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Wm. H. Hildon</u>				<u>Ellen A. Hildon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mrs. Elizabeth H. Hildon</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Old age</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 12, 1955</u> , to <u>June 11, 1956</u> , that I last saw the deceased alive on <u>June 12, 1955</u> , and that death occurred at <u>5:04 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wendell Phillips M.D.</u>				ADDRESS (Street, city, town, state) <u>Rock Run, Harford Co., Md.</u>		DATE SIGNED <u>4/5/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 7, 1956</u>		<u>Rock Run</u>		<u>Harford Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Bertine B. Knight</u>		<u>H.D. Bailey</u>		<u>Wilmington</u>	
DATE <u>Jan. 7, 1956</u>							



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

659

## CERTIFICATE OF DEATH

00661

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Hfd</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		LENGTH OF STAY (in this place) <u>2 hrs. 45 Min</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Douglas Ray Starr</u>				<b>4. DATE OF DEATH</b> (Month) <u>Jan</u> (Day) <u>24</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Single</u>	<b>8. DATE OF BIRTH</b> <u>Jan. 24, 1956</u>	<b>9. AGE last birthday</b> <u>1 yr.</u>		<b>10. IF UNDER 1 YEAR</b> Months <u>2</u> Days <u>45</u> Hours <u>15</u> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>Marshall Willis Starr</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Norma Stemper</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A) <u>Asphyxia due to unknown</u>						<u>2 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>cause</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, of INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Jan 24</u>, 19<u>56</u>, to <u>Jan 24</u>, 19<u>56</u>, that I last saw the deceased alive on <u>Jan 24</u>, 19<u>56</u>, and that death occurred at <u>7:15 PM</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Philip W. Keenan</u>				<b>DATE SIGNED</b> <u>M.D. 307 Healey, Belkin, Md</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Jan 25, 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Mountain Christian</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Joppa Md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Priscilla Lowwood</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. H. Archer</u>		<b>ADDRESS</b> <u>Brown Md</u>	
<b>DATE</b> <u>1-26-56</u>							

1000 1000 1000

1000 1000 1000

1000 1000 1000



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and immediately filled in by the funeral director, the third copy of this death certificate assembly should be attached for use as a burial transit permit.

VS AISE 1-55 101

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

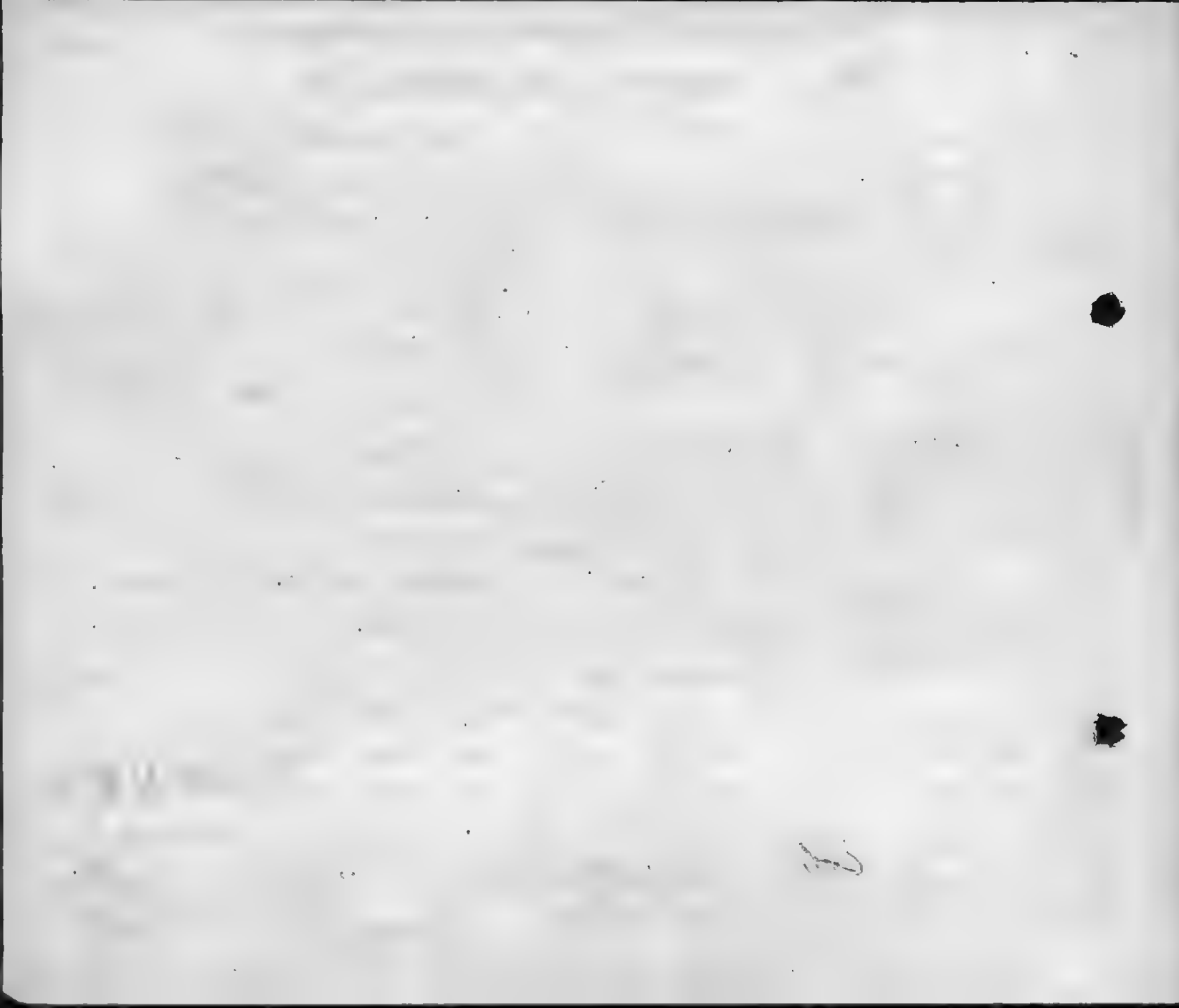
00662

078

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>Jarrettsville</u>		<u>30 yrs</u>		TOWN <u>Jarrettsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>EMMA</u> (Middle) <u>M</u> (Last) <u>STREETT</u>				(Month) <u>Jan</u> (Day) <u>2</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>Apr 14 1864</u>	<u>91</u> yrs.	Months <u>5</u>	Days <u>22</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSE WIFE</u>		<u></u>		<u>Jarrettsville MD</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Samuel Streett</u>				<u>MARY Ellen Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>MD</u>		<u></u>		<u>Mrs Virginia S Jarrett MD Jarrettsville</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
4. IMMEDIATE CAUSE (A) <u>Acute Myocardial Insufficiency</u>						<u>Sudden.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardio-vascular Disease.</u>						<u>Years.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized Arterio-sclerosis.</u>						<u>Years.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>53</u> , to <u>1/6/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/2/56</u> , 19 <u>56</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)				DATE SIGNED	
<u>Edwin B. J. [Signature]</u>		<u>M.D. 11 East Chase St., Baltimore-2, Md.</u>				<u>1/6/56.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 9 1956</u>		<u>Bethel</u>		<u>Madonna Heights MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>1-11-56</u>		<u>[Signature]</u>		<u>[Signature]</u>			



**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00663

660

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
31 TOWN <u>Aberdeen</u>				31 TOWN <u>Aberdeen</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>#306 Graceford Trine</u>				STREET ADDRESS <u>#132 Low Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Jordan</u> (Middle) <u>W.</u> (Last) <u>Tweed</u>				(Month) <u>Jan</u> (Day) <u>30</u> (Year) <u>1956</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify)	<b>8. DATE OF BIRTH</b>		<b>9. AGE last birthday</b>	<b>10. IF UNDER 1 YEAR</b>	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>June 8th 1896</u>		<u>59</u> yrs.	Months	Days
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY</b>	
<u>Electrician</u>		<u>Govt. H.P.G. Ind.</u>		<u>Pennsylvania</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>John W. Tweed</u>				<u>Mary Ellen Wright</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>		<u>220-22-0561</u>		<u>Wm Jordan W. Tweed #132 Low St. Aberdeen Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
420.1 IMMEDIATE CAUSE (A) <u>Arterio Sclerotic Cardio</u>						<u>5 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Coronary Thrombosis</u>						<u>6 min</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Jan 30, 1956</u> , <b>to</b> <u>Jan 30, 1956</u> , <b>that I last saw the deceased alive on</b> <u>Jan 30, 1956</u> , <b>and that death occurred at</b> <u>8:00 P.M.</u> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Charles J. Foley</u> M.D.				<b>DATE SIGNED</b> <u>Feb 2/1/56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>Feb 2-1956</u>		<u>Spesutie Cemetery</u>		<u>Perryman Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>Feb 1-1956</u>		<u>Mellie R. Perry</u>		<u>John G. Harding Aberdeen Md.</u>			

100000

STATE DEPARTMENT OF HEALTH - NEW YORK

# CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of coroner		12. Signature of jury	

BUREAU V. 2

FEB 3 1936

RECEIVED

NOTIFICATION  
The undersigned, being a duly qualified physician, do hereby certify that the above named person died on the 3rd day of February, 1936, at the age of 35 years, of the disease of the heart, and that the death was caused by the disease of the heart, and that the death was not caused by any other disease or injury.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00664

661

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		STATE <u>MD</u>		COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HAVERDE GRACE</u>		<u>43 YEARS</u>		TOWN <u>HAVERDE GRACE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>NONE</u>				<u>124 Lodge ALLEY</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>MARTHA</u> (Middle) <u>LENA</u> (Last) <u>WEBSTER</u>				(Month) <u>JAN</u> (Day) <u>15</u> (Year) <u>1956</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>F</u>	<u>N</u>	<u>WIDOWED</u>	<u>OCT 12 1876</u>	<u>79</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>HOUSEWIFE</u>		<u>NONE</u>		<u>Port Deposit, MD</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>John Bond</u>				<u>SUSAN BESSECK</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>NO</u>		<u>NO</u>		<u>UNKNOWN David H Webster, Lodge ALLEY</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>420.1</u> IMMEDIATE CAUSE (A) _____				<u>Coronary occlusion</u>			
ANTECEDENT CAUSE(S) DUE TO _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO _____							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
				<u>15 minutes</u>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town)		(County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>January 15, 1956</u> to <u>January 15, 1956</u>, that I last saw the deceased alive on <u>January 15, 1956</u>, and that death occurred at <u>7 P.</u> M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>C. J. V. Simon</u>				<b>DATE SIGNED</b> <u>Jan 18 1956</u>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b> (State)	
<u>BURIAL</u>		<u>1/18/1956</u>		<u>ST. JAMES</u>		<u>HAVERDE GRACE, MD</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>Jan. 18 - 1956</u>		<u>A. L. Lewis M. D.</u>		<u>Cemeterian + Jan. 18, 1956</u>			

100001

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALTIMORE 12

# CERTIFICATE OF DEATH

BUREAU V. S.

JAN 30 1956

RECEIVED

STATISTICS